Supreme Court U.S.
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No. ____

In the
Supreme Court of the United States

MANDY R., by and through her parents and guardians, Mr. and Mrs. R., *et al.*
Petitioners,

v.

BILL RITTER, Governor of the State of Colorado, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Does federal Medicaid law, which requires that medical assistance be furnished with reasonable promptness to all eligible individuals and may not be less in amount, duration, and scope to the medical assistance made available to similarly situated others, impose on a state an obligation to ensure that the care and assistance specified in the state's Medicaid plan is promptly furnished when the state plan provides it will furnish it with "no limitations", either privately or publicly? Or may the state discharge its federal Medicaid obligation by merely making prompt payment when presented with a charge for such care and assistance and place Medicaid eligible persons on waiting lists until services are provided?

PARTIES TO THE PROCEEDING

The Petitioners are Mandy R., by and Through Her Parents and Guardians, Mr. and Mrs. R.; Stephanie F., by and Through Her Parents and next Friends, Mr. and Mrs. F.; Marian L., by and Through Her Parent and Guardian Ms. L.; and Cathy G., by and Through Her Parent and Guardian, Russell G.

The Respondents are Bill Ritter, Governor of the State of Colorado; Karen Beye, Director of the Colorado Department of Human Services; and Joan Hanneberry, Director of the Colorado Department of Health Care Policy and Financing.

The Colorado Association of Community Centered Boards, does not join in this petition, and Jodi F. and Lisa W., as individuals, also do not join in this petition. Respondents are public officials who have been substituted automatically pursuant to Supreme Court Rule 35(3) because a change of administration occurred in Colorado on January 9, 2007. Pursuant to the order of the trial court, last names of the petitioners were not to be divulged except upon order of the court.

TABLE OF CONTENTS

QUESTION PRESENTED i

PARTIES TO THE PROCEEDING ii

TABLE OF CONTENTS iii

TABLE OF AUTHORITIES vi

CITATION OF OPINIONS ENTERED IN THE CASE 1

BASIS FOR SUPREME COURT JURISDICTION 1

STATUTES AND REGULATIONS INVOLVED IN THE CASE 1

STATEMENT OF THE CASE 2

A. INTRODUCTION 2

B. FEDERAL MEDICAID REQUIREMENTS . . . 5

C. COLORADO'S MEDICAID PLAN FOR THE DEVELOPMENTALLY DISABLED 5

D. WAITING LISTS 8

E. TRIAL BEFORE THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLORADO 9

F. THE TENTH CIRCUIT COURT OF APPEALS 10

REASONS FOR GRANTING THE PETITION 12

A. CERTIORARI SHOULD BE GRANTED BECAUSE A SUBSTANTIAL CONFLICT EXISTS BETWEEN *MANDY R.* AND DECISIONS OF THE FIRST, THIRD, AND ELEVENTH CIRCUITS 12

B. *MANDY R.* CONFLICTS WITH THE MEDICAID ACT AND PRESENTS AN IMPORTANT QUESTION OF FEDERAL LAW THAT SHOULD BE SETTLED BY THIS COURT 17

1. COLORADO'S MEDICAID PLAN IS NOT LIMITED TO PAYING MEDICAID PROVIDERS ONLY; COLORADO IS A MEDICAID PROVIDER OF ICF/MR SERVICES 18

2. THE REASONABLE PROMPTNESS STATUTE REQUIRES SERVICES TO BE FURNISHED TO ALL ELIGIBLE INDIVIDUALS WITHOUT DELAY 19

3. THE COMPARABILITY STATUTE DOES NOT PERMIT SIMILARLY SITUATED MEDICAID RECIPIENTS TO RECEIVE SERVICES WHILE OTHERS ARE PLACED ON LENGTHY WAITING LISTS 24

4. 42 U.S.C. § 1396d(a) DOES NOT LIMIT STATE MEDICAID PLANS TO FINANCIAL ASSISTANCE ONLY 26

CONCLUSION 28

APPENDIX

Appendix A: 10/23/06 Circuit Court Order 1a

Appendix B: 9/21/06 Circuit Court Opinion 4a

Appendix C: 3/1/05 District Court Judgment 23a

Appendix D: 2/28/05 District Court Memorandum and Order 25a

Appendix E: 6/1/04 Stipulation of Facts 46a

Appendix F: Excerpt from Current State Medicaid Plan March 1991 Amount, Duration and Scope of Medical Remedial Care and Services Provided to the Categorically Needy 59a

Appendix G: Excerpts of Statutes and Regulations:
10 C.C.R. 2505-10, §8.403.11 . . . . . 61a
10 C.C.R. 2505-10, §8.441.3F 66a
42 C.F.R. § 435.911 . . . . . 68a
42 C.F.R. § 435.930 . . . . . 72a
42 C.F.R. § 440.230 . . . . . 74a
42 C.F.R. § 483.440 . . . . . 76a
42 U.S.C. § 1396a 71a
42 U.S.C. § 1396d 88a
42 U.S.C. § 1396n 94a

TABLE OF AUTHORITIES

CASES

Alabama Nursing Home Association v. Harris,
617 F.2d 388 (5th Cir. 1980) 9

Alexander v. Choate, 469 U.S. 287(1985) 5

Antrican v. Buell,
158 F. Supp. 2d 663 (E.D. NC. 2001) 23

Blessing v. Freestone, 520 U.S. 329 (1997) 2, 19

Boulet v. Cellucci 107 F. Supp. 2d 61 (D. Mass. 2000) . 23

Bruggeman v. Blagojevich,
324 F.3d 906 (7th Cir. 2003) . . . . . *passim*

Bryson v. Shumway, 308 F.3d 79 (1st Cir. 2002) . . *passim*

Cannon v. University of Chicago, 441 U.S. 677 (1979) . 2

Chevron v. Natural Resources Defense Council,
467 U.S. 837 (1984) 22

Clark v. Richman,
339 F. Supp. 2d 631 (M.D. PA. 2004) 23

Doe v. Chiles, 136 F.3d 709 (11th Cir. 1998) . . . . *passim*

Equal Access for El Paso v. Hawkins,
428 F. Supp. 2d 585 (W.D. Tex. 2006) 23

Gonzaga University v. Doe, 536 U.S. 273 (2002) . . *passim*

Harris v. McRae, 448 U.S. 297 (1980) 5, 17

Health Care for All, Inc. v. Romney,
2005 WL 1660677 (D. Mass. 2005) 14

Martin v. Taft, 222 F. Supp. 2d 940 (S.D. Ohio 2002) . 23

McMillan v. McCrimon,
807 F. Supp. 475 (C.D. Ill. 1992) 23

Michelle P. ex rel Diesenroth v. Holsinger,
356 F. Supp. 2d 763 (E.D. Ky. 2005) 23

Miller v. Whitburn, 10 F.3d 1315 (7th Cir. 1993) 3

Mitchell v. Johnston, 701 F.2d. 337 (5th Cir. 1983) . . . 26

Oklahoma Chapter of the American Academy of Pediatrics v. Fogarty,
____ F.3d ____, 2007 WL 10760 (10th Cir. 2007) . 12

Olmstead v. Zimring, 527 U.S. 581 (1999) 10

Pediatric Specialty Care v. Arkansas,
293 F.3d 472 (8th Cir. 2002) 3

Rabin v. Wilson-Coker, 362 F.3d 190 (2nd Cir. 2004) . . 3

Sabree v. Richman, 367 F.3d 180 (3rd Cir. 2004) . . *passim*

S.D. ex. rel. Dickson v. Hood,
391 F.3d 581 (5th Cir. 2004) 3

Sobky v. Smoley,
855 F. Supp. 1123 (E.D. Cal. 1999) 23, 25

Watson v. W 436 F.3d 1152 (9th Cir. 2006) 3

Westside Mothers v. Haveman,
289 F.3d 852 (6th Cir. 2002) . . . . . *passim*

Westside Mothers v. Olzewski,
454 F.3d 532 (6th Cir. 2006) . . . . . *passim*

White v. Beal, 555 F.2d 1146 (3rd Cir. 1977) 25

Wilder v. Virginia Hospital Association,
496 U.S. 498 (1990) 17, 20, 28

STATUTES

1. FEDERAL STATUTES:

28 U.S.C. § 1254(1) 1
28 U.S.C. § 2101(c) 1
42 U.S.C. § 1396a(a) 17, 26, 27
42 U.S.C. § 1396a(a)(8) . . . . . *passim*
42 U.S.C. § 1396a(a)(9) 27
42 U.S.C. § 1396a(a)(10) 3
42 U.S.C. § 1396a(a)(10)(B)(i) . . . . . *passim*
42 U.S.C. § 1396a(a)(10)(C)(iv) 5
42 U.S.C. § 1396a(a)(11)(A) 27
42 U.S.C. § 1396a(a)(19) 27
42 U.S.C. § 1396a(a)(23) 20, 27
42 U.S.C. § 1396a(a)(31) 27
42 U.S.C. § 1396a(a)(33) 27
42 U.S.C. § 1396a(a)(62) 27
42 U.S.C. § 1396a(a)(65) 20
42 U.S.C. § 1396a(b) 17
42 U.S.C. § 1396d(a) . . . . . *passim*

42 U.S.C. § 1396d(a)(4)(B) 3
42 U.S.C. § 1396d(a)(13) 3
42 U.S.C. § 1396d(a)(15) 3, 24
42 U.S.C. § 1396d(b) 9
42 U.S.C. § 1396n(c) 1, 5
42 U.S.C. § 1396n(c)(3) 6
42 U.S.C. § 1396n(c)(2)(C) 7, 20
42 U.S.C. § 1396n(c)(5)(A) 6
42 U.S.C. § 1396r-6 3
42 U.S.C. § 1983 . . . . . 2, 3, 4

2. STATE STATUTES:

§ 25.5-4-103(9), C.R.S. (2006). 19
§ 25.5-5-202, C.R.S. (2006) 5
§ 27-1-104(d),(e), C.R.S. (2006) 18
§ 27-10.5-102(3), C.R.S. (2006) 4
§ 27-10.5-104(1)(e) C.R.S. (2006) 9

REGULATIONS

3. FEDERAL REGULATIONS:

42 C.F.R. § 435.911 1
42 C.F.R. § 435.911(a) 13
42 C.F.R. § 435.911(e)(1) 15
42 C.F.R. § 435.930 . . . . . *passim*
42 C.F.R. § 440.230 1
42 C.F.R. § 440.240(b) 26
42 C.F.R. § 483.440(a)(1) 1, 6

4. STATE REGULATIONS:

10 C.C.R. 2505-10, § 8.403.11 2
10 C.C.R. 2505-10, § 8.441.3F 2, 18

5. OTHER AUTHORITIES

David Braddock, The State of the States in Developmental Disabilities, 2005, American Center for Retardation, Washington, D.C. 4, 12

Wiggins, Medicaid and the Enforceable Right to Recover Medical Assistance: The Need for a Definition of "Medical Assistance", William and Mary Law Review, February 2006 16

CITATION OF OPINIONS ENTERED IN THE CASE

Mandy R. v. Owens, 464 F.3d. 1139 (10th Cir. 2006).

The opinion of the trial court was not reported. It is included in the appendix. App. 23a.

BASIS FOR SUPREME COURT JURISDICTION

The United States Court of Appeals for the Tenth Circuit entered its judgment on September, 21, 2006. App. 4a, 22a. Rehearing was denied on October 23, 2006. App. 1a, 3a. Petitioners seek review of that judgment on a writ of certiorari. The petition is timely filed pursuant to 28 U.S.C. §2101(c) and Rule 13.3 of this Court.

This Court has jurisdiction under 28 U.S.C. § 1254(1) to review on a writ of certiorari the judgment of a federal court of appeals.

STATUTES AND REGULATIONS INVOLVED IN THE CASE

The following statutes and regulations are set forth in the appendix:

42 U.S.C. §1396a(a)(8)	App. 84a
42 U.S.C. §1396a(a)(10)(B)(i)	App. 86a
42 U.S.C. §1396d(a)	App. 88a
42 U.S.C. §1396n(c)	App. 94a
42 C.F.R. §435.911	App. 68a
42 C.F.R. §435.930	App. 72a
42 C.F.R. §440.230	App. 74a
42 C.F.R. §483.440	App. 76a-77a

10 C.C.R. 2505-10, §8.403.11	App. 61a-65a
10 C.C.R. 2505-10, §8.441.3F	App. 66a-67a

STATEMENT OF THE CASE

A. INTRODUCTION

On August 25, 2000, three developmentally disabled residents of Colorado filed suit pursuant to 42 U.S.C. § 1983 against the Governor of Colorado and the executive directors of two state departments alleging that they were eligible for Medicaid funded services in intermediate care facilities for the developmentally disabled or mentally retarded (ICF/MR), but instead had been placed on lengthy waiting lists for services due to lack of state funding. The three plaintiffs claimed that they were denied ICF/MR services which were required to be furnished to them with "reasonable promptness" under 42 U.S.C. § 1396a(a)(8) (the "reasonable promptness statute") and that those similarly situated received the services they could not, and that such refusal of services violated 42 U.S.C. § 1396a(a)(10)(B)(i) (the "comparability statute").

Plaintiffs claimed that the two above referenced Medicaid statutes created federal enforceable rights pursuant to this Court's three part test in *Blessing v. Freestone,* 520 U.S. 329 (1997). During the pendency of this case, this Court decided *Gonzaga University v. Doe,* 536 U.S. 273 (2002). In *Gonzaga,* the Court reaffirmed the *Blessing* test, clarifying that in order for Congress to create a federal right the text of the statute must be "phrased in terms of the persons benefitted." *Gonzaga* at 284 (citing *Cannon v. University of Chicago,* 441 U.S. 677, 692, n.13 (1979)). The Tenth Circuit Court of Appeals observed that at least six federal circuit courts had found a private right to sue for enforcement of these two Medicaid provisions (or closely related

provisions) and assumed, without deciding, that § 1983 gave the plaintiffs such rights. App. 10a.[1]

The reasonable promptness claim was identical to a successful claim brought in a similar suit in the United States District Court for the Southern District of Florida on behalf of a class of developmentally disabled individuals placed on waiting lists for ICF/MR services. In *Doe, supra,* n.1, the Eleventh Circuit Court of Appeals affirmed the district court's entry of an injunction against Florida officials requiring that persons receive ICF/MR services within ninety days of the date they were found eligible for Medicaid. The Eleventh Circuit found that these delays violated § 1396a(a)(8), and

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[1] *See, Watson v. Weeks,* 436 F.3d 1152, 1159, n.8 (9th Cir. 2006) (enforcing §1396a(a)(10)); *Sabree v. Richman,* 367 F.3d 180, 192 (3rd Cir. 2004) (enforcing §1396a(a)(8), §1396a(a)(10) and §1396d(a)(15)); *S.D. ex. rel. Dickson v. Hood,* 391 F.3d 581, 597 (5th Cir. 2004) (enforcing §1396d(a)); *Westside Mothers v. Haveman,* 289 F.3d 852, 863 (6th Cir. 2002) (enforcing §1396a(a)(8) and §1396a(a)(10)); *but, see, Westside Mothers v. Olzewski,* 454 F.3d 532, 540 (6th Cir. 2006) (enforcing payment but not actual services) (hereinafter *"Westside Mothers II"*); *Pediatric Specialty Care v. Arkansas,* 293 F.3d 472, 480 (8th Cir. 2002) (enforcing §1396a(a)(10) and §1396d(a)(13)); *Miller v. Whitburn,* 10 F.3d 1315, 1319 (7th Cir. 1993) (enforcing §1396a(a)(10) and §1396d(a)(4)(B)); *but see, Bruggeman v. Blagojevich,* 324 F.3d 906, 910 (7th Cir. 2003) (suggesting Medicaid is only a payment scheme). In addition to the six circuit cases referenced by the Tenth Circuit are the following decisions from the First, Second, and Eleventh Circuits, which enforced the same or similar provisions of the Medicaid Act: *Rabin v. Wilson-Coker,* 362 F.3d 190, 201-02 (2nd Cir. 2004) (enforcing §1396r-6); *Bryson v. Shumway,* 308 F.3d 79, 88 (1st Cir. 2002) (enforcing §1396a(a)(8); *Doe v. Chiles,* 136 F.3d 709, 719 (11th Cir. 1998) (enforcing §1396a(a)(8)).

could be privately enforced and remedied pursuant to § 1983. *Doe* at 719.

Prior to the trial in this case, three additional plaintiffs were permitted to intervene into the lawsuit.[2] The Colorado Association of Community Centered Boards (CACCB) was also permitted to intervene on behalf of the plaintiffs. The CACCB is an association of twenty community centered boards whose members perform intake, determine Medicaid eligibility, develop treatment plans and broker services for persons with developmental disabilities. *See*, C.R.S. § 27-10.5-102(3) (2006). Petitioners and the CACCB claimed that Colorado was violating federal Medicaid law in placing plaintiffs and hundreds of similarly situated others on waiting lists. The CACCB also brought a "rates claim" alleging that inadequate reimbursement rates were a significant cause of the delays and consequent deterioration of services to the developmentally disabled in Colorado.[3] CACCB claimed that inadequate rates violated federal law. The rates claim was dismissed by the trial court which was affirmed by the Tenth Circuit. App. 20a. Petitioners do not assert the rates claim here.

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[2] One plaintiff received the relief she sought during the pendency of this case prior to trial and did not appeal. A second plaintiff does not join in this petition.

[3]According to David Braddock, a recognized authority on services to the developmentally disabled, Colorado ranked 44th in fiscal effort for services to the developmentally disabled nationwide in 2005. *See*, David Braddock, *et. al.*, The State of the States in Developmental Disabilities, p. 56, Table 16, (2005), American Association of Mental Retardation, Washington, D.C.

B. FEDERAL MEDICAID REQUIREMENTS

Services in ICF/MR facilities are state optional services pursuant to 42 U.S.C. §1396a(a)(10)(C)(iv). App. 87a. Colorado has opted to provide ICF/MR services. § 25.5-5-202(1)(h), C.R.S. (2006). Once an option is selected by a state, it becomes binding on the state and is subject to the full requirements of federal law. *Harris v. McRae,* 448 U.S. 297, 301 (1980). Pursuant to §1396a(a)(8), Medicaid services "must be furnished with reasonable promptness" to all eligible persons. App. 84a. Under §1396a(a)(10)(B)(i) services provided to individuals within the same categorically eligible group of individuals must be of the "same amount, duration, and scope" so that individuals are treated equally. App. 86a. *See*, *Alexander v. Choate,* 469 U.S. 287 (1985) (Tennessee may limit hospitalizations to 14 days if Medicaid recipients treated equally).

C. COLORADO'S MEDICAID PLAN FOR THE DEVELOPMENTALLY DISABLED

Colorado provides comprehensive residential services and treatment to the developmentally disabled in two programs: Home and Community Based Services to the Developmentally Disabled (HCBS-DD) and ICF/MR facilities. The HCBS-DD program is authorized pursuant to 42 U.S.C. § 1396n(c). App. 94a. HCBS-DD services are provided as an alternative to ICF/MR services and are typically provided in private homes, apartments, group homes, or host homes. Stipulation of Facts 3, App 47a. HCBS-DD programs are not usually operated directly by the state, although they can be. The HCBS-DD program must provide "habilitation services" which are defined as services "designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside

successfully in home and community based settings". §1396n(c)(5)(A). App. 97a. At the time of trial, Colorado capped participation in this program at 3,807 persons and the program was operating at its full capacity. App. 30a. Unlike ICF/MR facility services, HCBS-DD services do not need to be offered uniformly state wide and participation is limited pursuant to a waiver granted by the Centers for Medicare and Medicaid Services (CMS). The comparability statute is expressly waived in all HCBS-DD programs. *See*, § 1396n(c)(3). App. 96a.

The ICF/MR program used to be the only program Colorado operated until the HCBS-DD program began in the 1980's. The ICF/MR program, with one exception, provides direct services operated and controlled by the state. App. 29a, 30a. Except for the one private ICF/MR, the state owns the facilities, hires the staff, admits individuals to its facilities, and receives Medicaid dollars from the federal government to operate the program.

Waivers are not permitted in the ICF/MR program. The state Medicaid plan promises to provide these services with "no limitation." App. 59a. Under federal regulations, ICF/MR facilities must provide a "continuous active treatment program which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services." 42 C.F.R. § 483.440(a)(1) (2006). App. 76a, 77a. At the time of trial, Colorado served 42 individuals at its Grand Junction Regional Center and 28 individuals at Kipling Village at Wheat Ridge Regional Center. *See*, Stipulation of Facts, 6,7. App. 48a. Sixteen individuals were serviced at Good Shepherd, the only private ICF/MR facility in the state. Good Shepherd is currently operated for developmentally disabled persons with high medical needs. *See*, Stipulation of Facts 8. App. 48a.

Colorado has limited participation in state ICFs/MR despite the "no limitation" pledge set forth in its state Medicaid plan. In order to be admitted into one of the two state operated ICFs/MR, one must be a sex offender or a "high risk person". Stipulation of Facts 6,7. App. 48a. None of the petitioners were sexual offenders. One Petitioner, Cathy G., was considered "high risk" and treatment was recommended to a state regional center ICF/MR in August of 2001. Stipulation of Facts 56. App. 55a. Cathy G. was never placed at a regional center. The state limits on participation are policy decisions made by Colorado in order to manage the demand for services. Petitioners maintain that these restrictions violate the comparability statute. All of the petitioners met the level of care requirements for placement into an ICF/MR facility. Stipulation of Facts 35, 41, 57, 64. App. 52a-56a. Yet, they are restricted from being admitted due to the state's policies.

The two programs contain qualitative and quantitative differences. HCBS-DD programs are operated through community centered boards; ICF/MR facilities are administered through the Colorado State Department of Human Services. HCBS-DD services are capped by CMS waiver; ICFs/MR cannot be capped. Colorado has historically preferred HCBS-DD programs to ICF/MR programs and has downsized state operated ICF/MR facilities since the late 1970s. Stipulation of Facts 10. App. 49a. Unfortunately, neither program has kept pace with population growth leading to the problem of waiting lists.

Because differences exist between the two programs, federal Medicaid law requires that individuals be given a choice between waiver services, if feasible, or services in ICF/MR facilities. § 1396n(c)(2)(C). App. 95a. Services in HCBS-DD facilities are not feasible for the petitioners

because of the population cap, although in some cases these services may be preferable. The population cap was not challenged by the petitioners because Colorado has been allowed the waiver of comparability by CMS. The only realistic alternative remaining for petitioners then is the ICF/MR which petitioners claim is a service entitlement under the state Medicaid plan.

D. WAITING LISTS

Colorado does not provide or pay for services for everyone who needs services because of lack of funding.[4] Hence, Colorado has created waiting lists for both HCBS-DD and ICF/MR services. Colorado estimated that by fiscal year 2005 there would be at least 892 persons on waiting lists for comprehensive residential services and treatment, either waiting for HCBS-DD or ICF/MR placements. Stipulation of Facts 16. App. 50a. At least 21 of these individuals were specifically seeking ICF/MR services, including all of the petitioners. Stipulation of Facts 9, App. 48a, 49a. Approximately half of the total wait-listed individuals received no state services of any kind.[5] App. 8a.

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[4] At oral argument before the Tenth Circuit, the State acknowledged that it would have to pay for ICF/MR services if it was presented with a bill for services from a private provider. However, because of the fact that most ICF/MR services are in state run institutions and the state limits bed capacity in private ICF/MR facilities, the plaintiffs claimed this was a pretext for failure to comply with the state Medicaid plan.

[5] Some individuals received day services and supports. Although these services are not comprehensive residential treatment services, day services and supports are limited services such as

E. TRIAL BEFORE THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLORADO

After a four day bench trial in June 2004, the trial court held that the claims of the plaintiffs and intervenors were "untenable" because federal courts could not require Colorado to "raise and spend enough money to expand DD care facilities to meet demands that are beyond its control and without the support of federal funding."[6] App. 37a. Implicit in the trial court's findings of fact was its conclusion that Colorado was not providing adequate care for all eligible developmentally disabled persons. The court wrote:

> [I]f this court were to agree with the contention that, by accepting the benefit of partial funding of the cost of care provided, the States must assume the duty of adequate care for all eligible DD, it must decide Colorado has not been complying with that obligation. The state legislature has not provided enough money to build and staff enough ICF/MR facilities to meet existing demand and there has been a preference for ICF/MR care in the existing state institutions in favor

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safety awareness, job coach, and recreational opportunities. *See*, C.R.S. §27-10.5-104(1)(e)(2006).

[6] The federal government will cover at least 50% of Colorado's Medicaid expenditures. *See*, 42 U.S.C. §1396d(b). Difficulty in raising revenue at the state level does not dispense with the State's obligations under a federally approved Medicaid plan. *See, e.g. Alabama Nursing Home Association v. Harris*, 617 F.2d 388, 396 (5th Cir. 1980). *Accord, Doe* at 722.

> of HCBS services because they are thought to be more effective, as well as required by *Olmstead*.[7]

App. 39a.

Despite the clear and unambiguous language of the state Medicaid plan and the federal comparability statute, the trial court held it "can't order the state to provide any particular level of ICF/MR services or to keep them in its State Plan."[8] App. 40a. Petitioners then appealed that ruling.

F. THE TENTH CIRCUIT COURT OF APPEALS.

The Tenth Circuit affirmed the judgment of the trial court but adopted none of its reasoning. The appeals court accepted the fact that the plaintiffs were not receiving reasonably prompt or comparable level of services. App. 10a, 11a. However, in the Tenth Circuit's view, Colorado was not required to provide direct ICF/MR services to petitioners because its obligations under the Medicaid Act were to provide only "payment for services." App. 14a.

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[7] The reference to *Olmstead v. Zimring*, 527 U.S. 581 (1999), was perplexing because under Colorado regulations, ICF/MR facilities can be small community based facilities composed of only four residents, and services do not have to be delivered in large institutional settings. See, Stipulation of Facts 1. App. 46a, 47a. Moreover, *Olmstead* was not a Medicaid case. Petitioners were arguing about receiving no services to meet their needs, not arguing about being placed in unintegrated large facilities or hospitals when smaller community based facilities were available.

[8] Colorado produced no evidence at trial it intended to amend the state plan.

Addressing petitioners' argument that the state Medicaid plan obligated Colorado to provide ICF/MR services in both public and private facilities with "no limitations", the appeals court stated that the "no limitations" obligation was consistent with a financial payment limitation and that "there is no indication that by checking this box [on a federal form] the state promised to build, staff and maintain as many ICFs/MR as would be needed to meet the demand in Colorado." App. 13a, 14a. Further addressing petitioners' argument that the comparability statute means more than just payment for services, the appeals court stated that "this provision does not indicate which meaning we should give to 'medical assistance' and it thus gives us no reason to depart from the general statutory definition [of 'medical assistance'] from the Medicaid Act." App. 12a, 13a.

The Tenth Circuit concluded that "[w]e therefore agree with the Sixth and Seventh Circuits that the Medicaid statute does not require states to be service providers of last resort." It held that Medicaid was a financial assistance program and that *dicta* in *Bruggeman* at 910, *supra,* n.1, was "directly on point and persuasive." App. 16a. In adopting *Bruggeman,* the appeals court noted that it was departing from contrary opinions in the First and Eleventh Circuits, which enforced rights to Medicaid services in waiting list cases. App. 11a. *See*, *Bryson,* at 81, 88-89, *supra*, n.1., and *Doe,* at 714, 717, *supra,* n.1.

Petitioners assert that the Tenth Circuit erroneously interpreted federal Medicaid law and that its decision creates a conflict among the circuit courts of appeal. Due to the prevalence of "waiting list" cases throughout the United

States, petitioners assert that this issue is one of critical national importance.[9]

REASONS FOR GRANTING THE PETITION

A. CERTIORARI SHOULD BE GRANTED BECAUSE A SUBSTANTIAL CONFLICT EXISTS BETWEEN *MANDY R.* AND DECISIONS OF THE FIRST, THIRD AND ELEVENTH CIRCUITS.

Mandy R. directly conflicts with the decisions of the First Circuit in *Bryson,* and the Eleventh Circuit in *Doe.* It is also inconsistent with the decision of the Third Circuit in *Sabree, supra.* n. 1. *Mandy R.* is in accord with the decision of the Sixth Circuit in *Westside Mothers II, supra,* n.1, and the Seventh Circuit in *Bruggeman.* Recently, the Tenth Circuit reaffirmed its position in *Mandy R.* in *Oklahoma Chapter of the American Academy of Pediatrics v. Fogarty,* ____ F.3d ___, 2007 WL 10760 (10th Cir. 2007). The direct conflict was recognized by the court of appeals when it cited *Sabree* as follows: "There appears to be a disagreement among our sister courts of appeal as to whether, pursuant to Medicaid, a state must merely provide financial assistance to pay for covered services, or provide the services themselves." *Sabree* at 181, n.1.

The source of this disagreement originated with the Seventh Circuit decision in *Bruggeman.* There, developmentally disabled plaintiffs living at home in the

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[9] According to *Braddock, et. al.*, at 62, there were 22 active waiting list cases pending in the courts as of 2005. Braddock also reports that as of 2004 there were 75,288 persons nationally awaiting services. *Id.* at 60. The problem is growing.

Chicago metropolitan area filed a lawsuit against Illinois officials to "adopt a plan for expanding the number of ICF/DD's in the northern part of the state." *Bruggeman,* at 909. Their claim was based on the reasonable promptness statute. Concluding that "[t]he statutory entitlement to reasonable promptness of medical services [citation omitted] is not infringed by the maldistribution ... of ICF/DDS across the state," the court observed *in dicta* that "[M]edicaid is a payment scheme, not a scheme for state-provided medical assistance, as through state-owned hospitals." *Id.* at 910. *Bruggeman* was the first circuit court to conclude that Medicaid was only a payment scheme but it did not address 42 U.S.C. § 1396d(a) as the basis for its conclusion. *Bruggeman's* reasoning on this issue was scant and the opinion appeared to be based on an incorrect reading of 42 C.F.R. § 435.911(a) and § 435.930(a)-(b). These federal regulations are discussed *infra* at 15, 21, 22.

In *Westside Mothers II*, decided after oral argument in *Mandy R.*, the Sixth Circuit agreed with *Bruggeman* and held that Michigan did not have to provide medical services directly. *Westside Mothers II* at 540. The court held that both the reasonable promptness and the comparability statutes require only prompt determination of eligibility and "prompt payment to eligible individuals to enable them to obtain the necessary medical services." *Id.*[10] Despite this holding, *Westside Mothers II* implicitly acknowledged that the states have some obligations to ensure that Medicaid recipients actually receive services. Rates were cited as one example.

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[10] In an earlier decision in the same case, the Sixth Circuit determined that the failure of the state to provide ESPDT services to plaintiffs could be enforced via § 1983. *See, Westside Mothers v. Haveman, supra,* n.1.,at 863.

The court cited *Health Care for All, Inc. v. Romney*, 2005 WL 1660677 (D. Mass. 2005). Importantly, *Westside Mothers II* did not specifically address § 1396d(a).

Neither *Bruggeman* nor *Westside Mothers II* were cases where individuals were placed on lengthy waiting lists. In *Bruggeman,* services were available in southern Illinois but not in northern Illinois. Nevertheless, services were available somewhere in Illinois and plaintiffs were not on waiting lists for services. In *Westside Mothers II,* lack of services was identified as a problem of low rates to private providers and the case was remanded to the trial court for findings on that issue. *Westside Mothers II* at 541.

Bryson and *Doe,* however, were cases where developmentally disabled individuals had been placed on lengthy waiting lists for services, the same facts present here. The *Bryson* court found that the waiting lists were a "constraint on eligibility" and that where "slots were available" the slots had to be filled with reasonable promptness. *Bryson,* at 88. In other words, it was the waiting list itself that violated federal Medicaid law.

The *Doe* case presents a marked difference between it and the decisions in the Sixth, Seventh and Tenth Circuits. In *Doe,* as here, plaintiffs were waiting for services for many years for available openings in ICF/MR facilities. Hence, the plaintiffs in *Doe* could not receive the services "they so desperately need" and were "languishing" on waiting lists. *Doe* at 711.

Doe, however, properly focused on the State of Florida's obligations under the state Medicaid plan holding that "once a state elects to provide a service that service becomes part of the State Medicaid Plan and is subject to the requirements of

federal law." *Doe,* at 711-712. Interpreting 42 C.F.R. § 435.930(a)-(b) as a service guarantee, the *Doe* court found that Florida Medicaid officials "must ... [f]urnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures" and "[c]ontinue to furnish Medicaid regularly to eligible individuals until they are found to be ineligible." *Doe* at 714. The *Doe* court found no federal authority for a "waiting list" citing 42 C.F.R. §435.911(e)(1) which requires that a state agency "must not use the time stated as a 'waiting period'".

Another approach to the issue emerged with the decision of the Third Circuit in *Sabree.* This case was also a case where people were placed on waiting lists for ICF/MR services. Having found that plaintiffs in *Sabree* could enforce their federal rights to prompt and comparable services under the Medicaid Act, the *Sabree* court stated the issue then became a remedial issue to be decided by the trial court. *Sabree,* at 181, n.1. This viewpoint may be consistent with *Gonzaga* where this Court stated that "[p]laintiffs suing under § 1983 do not have the burden of showing an intent to create a private remedy because § 1983 generally supplies a remedy for the vindication of rights secured by federal statute". *Gonzaga* at 284. The precise remedy needed is left up to the trial court hearing the evidence. *Sabree* gave no guidance on how the trial court should decide the remedial issue.

Neither *Sabree* nor *Gonzaga* offer support for the *Mandy R.* decision. *Mandy R.* was a trial to the court and a detailed factual record was developed in the case. The trial judge denied summary judgment motions filed by both plaintiffs and defendants precisely so the court would have a better understanding of Colorado's state Medicaid plan. Despite this, the trial court did not base its decision on the evidence, finding that Colorado had a defense to providing ICF/MR

services because of inadequate state appropriations, not because it didn't have a direct service obligation. The legislature was faulted for this defalcation. Although the trial court correctly saw the legal issues as remedial and refused to grant relief only because the court believed it could not order Colorado to raise more money, the trial court conflated liability with remedy, misunderstanding the nature of Colorado's obligations under its state Medicaid plan.[11]

Instead of reversing the trial court and remanding the case back to decide the remedial issue based on holdings in *Sabree* and *Gonzaga,* the Tenth Circuit decided the case on new legal grounds articulated for the first time by the Sixth and Seventh Circuits that the states pay for services but never have to provide those services directly. Those grounds, however, did not fit well into the *Mandy R.* fact pattern and misapplied federal law. The decision went too far. Colorado has always been the major direct service provider of ICF/MR services. The appeals court failed to place the burden of proof on Colorado to demonstrate why it did not have an affirmative obligation to provide ICF/MR services under the state Medicaid plan.

The end result is circuit conflict and confusion over the nature of a state's obligations under the Medicaid Act. First, the Tenth Circuit's interpretation of § 1396d(a) that the state's Medicaid obligation is "financial assistance only" directly

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[11] In a 2006 law review article, the author suggests that awarding persons "medical assistance" is of little help without determining what the phrase means and that lower courts are split on the subject. Wiggins, Medicaid and the Enforceable Right to Recover Medical Assistance: The Need for a Definition of "Medical Assistance", William and Mary Law Review, February 2006.

conflicts with *Bryson* and *Doe,* which placed the Medicaid service obligation on the state. Second, the Tenth Circuit's decision that § 1396d(a) applies as a matter of law eviscerates the reasonable promptness and comparability statutes because it prevents enforcement of those statutes by aggrieved individuals in all cases except those involving financial payment regardless of what obligations a state undertakes in its state Medicaid plan. Finally, the Tenth Circuit's decision is inconsistent with *Sabree* in taking the remedial issue away from a trial court hearing the evidence.

Because there is inter-circuit disagreement on these fundamental issues arising under the Medicaid Act, this Court's review is appropriate.

B. *MANDY R.* CONFLICTS WITH THE MEDICAID ACT AND PRESENTS AN IMPORTANT QUESTION OF FEDERAL LAW THAT SHOULD BE SETTLED BY THIS COURT

This Court has long recognized that the purpose of the Medicaid Act is to fully implement "a cooperative federal-state program through which the federal government provides financial assistance to states so that they may *furnish medical care* to needy individuals". *Wilder v. Virginia Hospital Association,* 496 U.S. 498, 502 (1990) (emphasis supplied). Under the Act, the states develop a Medicaid plan which "contains a comprehensive statement describing the nature and scope of the State's Medicaid program". *Wilder,* at 502. The federal government then approves any plan that meets all of the conditions specified at 42 U.S.C. §1396a(a). *See*, 42 U.S.C. §1396a(b). Once approved, the plan becomes binding upon the state. *See, Harris,* at 301, *supra at 5.* Those principles would suffer substantial erosion if the states were

allowed to back away from service commitments made to the federal government in state Medicaid plans.

Colorado's Medicaid plan for services to the developmentally disabled is remarkable in its clarity and simplicity and should be enforced. It declares that it provides "intermediate care facility services ... for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care". App. 59a. Further, such care is provided in *both* public and private facilities with "no limitations". *Id.* Petitioners asserted at trial that Colorado's approved Medicaid plan imposed on the state a binding service obligation to provide both direct and indirect care. They asserted that this obligation rested on 1) the express language of the state Medicaid plan; 2) the reasonable promptness statute; and 3) the comparability statute. They further asserted that § 1396d(a) could not be construed to impose a limitation on Colorado's obligations to provide the care set forth in the state Medicaid plan. § 1396d(a) merely states what services the federal government will pay for and does not limit what a state may agree to in its state Medicaid plan.

1. COLORADO'S MEDICAID PLAN IS NOT LIMITED TO PAYING MEDICAID PROVIDERS ONLY; COLORADO IS A MEDICAID PROVIDER OF ICF/MR SERVICES

There is no requirement in the Medicaid Act that prohibits a state from obligating itself to provide direct care to needy individuals. If Colorado did not intend to provide direct care, it would not operate the Grand Junction Regional Center or Kipling Village at Wheat Ridge Regional Center. Yet, services in regional centers are required under state law to be under the control of the state. *See*, C.R.S. §27-1-104(d),(e) (2006). State law defines an intermediate nursing facility for

the mentally retarded as a "tax supported state-administered intermediate nursing facility, or a distinct part of such facility". C.R.S. §25.5-4-103(9) (2006).

ICF/MR facilities are state responsibilities. Although one private facility was licensed to be an ICF/MR, additional licensing requires state action. *See,* 10 C.C.R. 2505-10, §8.441.3F. App. 66a, 67a. Thus, the entire ICF/MR system is under the control of Colorado state officials. The state's argument that a private provider could enter this marketplace is just not possible under existing state law or regulation without agreement by the state.

Under Colorado's system of delivering services to the developmentally disabled, the Department of Human Services furnishes ICF/MR services and the Department of Health Care Policy and Financing pays for the services. Stipulation of Facts 19, 23, 24. App. 51a. The appeals court failed to appreciate the distinction. The decision of the Tenth Circuit effectively denies plaintiffs their federal right to enforce the state Medicaid plan even though they are the direct beneficiaries of the plan when the state simply refuses to do what it has promised to do. Because of *Mandy R.*, petitioners can now only enforce payment, and when no one provides services, the petitioners are left with nothing to enforce. Petitioners contend this largely undercuts § 1983 and the *Blessing* and *Gonzaga* tests in Medicaid cases.

2. THE REASONABLE PROMPTNESS STATUTE REQUIRES SERVICES TO BE FURNISHED TO ALL ELIGIBLE INDIVIDUALS WITHOUT DELAY

Waiting lists are inimical to the federal Medicaid scheme. Nowhere in federal Medicaid law are waiting lists tolerated.

§ 1396a(a)(8) states that medical assistance "shall be furnished with reasonable promptness to all eligible individuals". The word "furnish" is not the same as "payment". Furnish means "1. to equip with what is needed; 2. to supply." Webster's II New College Dictionary, 454 (1995).

Medicaid dollars are never paid to recipients to pay for care. Recipients receive services; providers receive payment. Thus, construing the word "furnish" as meaning "payment" does not describe the Medicaid system as it operates or how it was intended by Congress to operate. As this Court stated in *Wilder,* under Medicaid it is the states that "furnish medical *care* to needy individuals." *Wilder* at 502. (Emphasis supplied.)

Other provisions of the Medicaid Act would be rendered meaningless if "medical assistance" meant only "financial assistance." For instance, § 1396a(a)(23) requires a state plan to "provide that (A) any individual eligible for medical assistance (including drugs), may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required". Similarly, § 1396a(a)(65) requires that a state plan must "issue provider numbers for all suppliers of medical assistance consisting of durable medical equipment." If "medical assistance" meant payment only, Congress would not have included drugs and durable medical equipment as requirements under state plans. Clearly, what is "medical assistance" for purposes of the state plan is not limited to reimbursement only; the term must be read in conjunction with the services required to be provided in state plans.

§ 1396n(c)(2)(C) places service obligations on the state, not just payment obligations. In that statute, Congress

required that CMS not grant a waiver application under the HCBS-DD program unless the states

> (2) provide assurances satisfactory to the Secretary that ...
>
> > (C) such individuals who are determined likely to require the level of care provided in [an] ... intermediate care facility for the mentally retarded are informed of the feasible alternative, if available under the waiver, at the choice of such individual, to the provisions of... services in an intermediate care facility for the mentally retarded.

App. 95a.

The use of the words "provisions" and "services" belie a "financial assistance" only interpretation. In this subsection, states are instructed that its state Medicaid plan obligations cannot be used to replace ICF/MR service obligations with waiver services unless the waiver services are available and the individual consents. The Tenth Circuit's opinion that Colorado's waiver application "does not assign to the state, or any other party, the responsibility to ensure that such facilities are in fact available" creates a "Hobson's Choice" for individuals. It permits the state to violate statutory obligation.

Federal Medicaid regulations further support the states' obligation to "furnish Medicaid" as opposed to merely paying providers. Pursuant to 42 C.F.R. §435.930:

The agency must –

> (a) *Furnish Medicaid* promptly to recipients without any delay caused by the agency's administrative procedures;
>
> (b) continue to furnish Medicaid to all eligible individuals until they are found to be ineligible; and
>
> (c) make arrangements to assist applicants and recipients to get emergency medical *care* whenever needed, 24 hours a day and 7 days a week. (Emphasis supplied.)

App. 72a.

Clearly, CMS has expectations of the states beyond making payments only. To the extent there is any ambiguity in the statute, this interpretation by CMS is entitled to substantial deference. In *Chevron v. Natural Resources Defense Council,* 467 U.S. 837, 844, this Court held that "We have long recognized that considerable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer, and the principle of deference to administrative interpretations."

Moreover, if reasonable promptness meant financial payment to providers only, Medicaid recipients would rarely have occasion to enforce the reasonable promptness statute because they would have already received the services and only the provider would be waiting for payment. Such a construction of § 1396a(a)(8) is illogical. Congress was not concerned with providers; it was concerned with individuals

receiving prompt services. It is the services that needy people require, not reimbursement to their providers.[12]

Colorado's argument that services could be hypothetically available to people on waiting lists if they could locate private providers to deliver services to them is disingenuous. Even if that unlikely event were to occur, the waiting list itself would place some persons over others unless the individual arranging the services was first on the list. Thus, an individual would not be "furnished Medicaid" because of the agency's administrative procedures, i.e. the waiting list itself prevents services from being furnished. This of necessity violates 42 C.F.R. §435.930. *Bryson's* conclusion that waiting lists are a "constraint on eligibility" is compelling. See, *Bryson,* at 88 (citing *Boulet v. Cellucci,* 107 F. Supp. 2d 61, 77 (D. Mass. 2000)).

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[12] A majority of the federal district courts have interpreted §1396a(a)(8) to apply to actual medical services and not just payment for medical services. *See, e.g. Michelle P. ex rel Diesenroth v. Holsinger,* 356 F. Supp.2d 763 (E.D. Ky. 2005) (ICF/MR services); *Martin v. Taft,* 222 F. Supp.2d 940 (S.D. Ohio 2002) (developmental disability services); *Antrican v. Buell,* 158 F. Supp. 2d 663 (E.D. NC. 2001) (dental services); *Boulet v. Cellucci,* 107 F. Supp.2d 61 (D. Mass. 2000) (residential habilitation services); *Sobky v. Smoley,* 855 F. Supp. 1123 (E.D. Cal. 1999) (methadone treatments); *McMillan v. McCrimon,* 807 F. Supp. 475 (C.D. Ill. 1992) (home services). *But see, Equal Access for El Paso v. Hawkins,* 428 F. Supp. 2d 585 (W.D. Tex 2006); *Clark v. Richman,* 339 F. Supp. 2d 631 (M.D. PA. 2004).

3. THE COMPARABILITY STATUTE DOES NOT PERMIT SIMILARLY SITUATED MEDICAID RECIPIENTS TO RECEIVE SERVICES WHILE OTHERS ARE PLACED ON LENGTHY WAITING LISTS

42 U.S.C. § 1396a(a)(10)(B)(i) provides that a state plan for medical assistance must

> (10) provide
>
> > (B) That the medical assistance made available to any individual described in subparagraph (A)
> >
> > > (i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual.

App. 86a.

Subparagraph (A) individuals include at (A)(ii) optional groups of individuals entitled to receive ICF/MR services pursuant to § 1396d(a)(15). Thus, the comparability statute expressly applies to persons who wish to receive ICF/MR services and are eligible for such services.

The *Mandy R.*, court construed the "amount, duration, and scope" of medical assistance to be made available to all categorically eligible ICF/MR persons as consistent with a requirement for states "to pay for services on a comparable basis — in the same amount, for the same duration, and in the same scope." App. 12a. But the appeals court cited no authority for this construction of the statute. The reason it

cannot is that people on waiting lists could never receive payment in the same amount, for the same duration, or in the same scope as others because they aren't receiving any services. When no services are received, no payment can be made. Payment and services are inseparable in the Medicaid program.

Comparability, by definition, is denied to all those on waiting lists. In *Sobky, supra,* n. 12, a federal district court described California's arguments that individuals on waiting lists for methadone treatments were not denied comparability, as follows:

> The state's argument brings to mind Lord Keyne's rejoinder that "in the long run we are all dead". [Citation omitted.] In the long run all categorically needy persons may receive services. But in the meantime they do not, and life does not stop for them during the interim period. For anyone in immediate need of medical treatment, the value of medical services provided is less than the value of medical services provided when needed, particularly when the need is great.

Sobkey, at 1142.

Prior to *Mandy R.* and *Westside Mothers II,* no federal appellate court limited the comparability statute solely to payment.[13] *See, e.g. White v. Beal,* 555 F.2d 1146, 1149-51 (3rd Cir. 1977) (Pennsylvania's restriction on paying for eyeglasses based on cause of disability violated

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[13] Most of the cases listed *supra* at n. 1 were "comparability" cases.

comparability). *Mitchell v. Johnston,* 701 F.2d. 337, 346-347 (5th Cir. 1983) (failure of state to provide dental services to everyone because of state budgetary problems violated comparability statute). *Accord, Sabree, Doe,* and *Bryson, supra.*[14] *Mandy R.* and *Westside Mothers II* are minority views in the federal courts.

Federal Medicaid regulations do not support the interpretation that "amount, duration and scope" can apply to payment as opposed to services. *See,* 42 C.F.R. § 440.240(b) which states that "[t]he plan must provide that the *services available* to any individual in ... [the group] ... are *equal* in amount, duration and scope for *all* recipients within the group." (Emphasis supplied.). App. 75a. This regulation cannot logically be construed as limited to payment only.

4. 42 U.S.C. § 1396d(a) DOES NOT LIMIT STATE MEDICAID PLANS TO FINANCIAL ASSISTANCE ONLY

The definition of "medical assistance" in § 1396d(a) does not limit a State's obligations under its approved state Medicaid plan. Nothing in § 1396d(a) limits the state from being a service provider. States can and do operate hospitals, rural clinics, mental institutions and ICF/MR facilities. The Medicaid Act was enacted to expand medical care to needy individuals, not to contract it.

§ 1396a(a) contains a multitude of references to "public institutions" or "state agencies" which indicate that such

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[14] *Bruggeman* was not a comparability case. Services in *Bruggeman* were available in sufficient "amount, duration, and scope", just not in the same geographic location.

institutions or agencies may receive federal Medicaid dollars for certain care and services under the state plan directly to the state agency itself. These specific references in the Medicaid Act set forth state obligations beyond mere payment to third party providers. *See, e.g.* § 1396a(a)(9) (state agencies responsible for establishing health standards for both private and public institutions); § 1396a(a)(11)(A) (cooperative agreements required between state agencies administering health services and vocational rehabilitation services); § 1396a(a)(19) (states must ensure that care and services under the plan are provided to recipients in their best interests); § 1396a(a)(23) (drugs are medical assistance available from agencies or community pharmacies); § 1396a(a)(31) (state obligation to provide a written plan of care for all individuals in ICF/MR facilities); § 1396a(a)(33) (state agency requirements to undertake professional review of all care and services under the state plan); § 1396a(a)(62) (mandates states to provide distribution of pediatric vaccines to program-registered providers).

§ 1396d(a) does not separate payment from the services it was designed to purchase. The statute states that medical assistance "means payment of part or all of the cost of the following [enumerated] care and services." App. 88a. The emphasis is no less on the services provided than the payment necessary to purchase the service. Certainly, the phrase "medical assistance" does not negate a state's obligations under § 1396a(a).

The Tenth Circuit's conclusion that a state must only "pay promptly and evenhandedly for medical services when the state is presented with the bill", *see,* App. 11a, ignores much of the text in § 1396a(a), which places considerable nonfinancial obligations on the states. Where a state like Colorado obligates itself to be a service provider in its state

Medicaid plan, the services cannot be separated from payment. The state Medicaid plan is more than a good faith requirement; it is a legally binding obligation that the services promised in the plan will actually be delivered to those in need of them. That obligation is a state obligation and the state cannot cast itself into the same role played by the federal government. Otherwise, *Wilder's* command that under Medicaid the federal government pays the states to provide "care to needy individuals," *Wilder* at 502, rings hollow.

CONCLUSION

For the reasons and based upon the authorities set forth in this Petition, petitioners respectfully request that the Petition for Writ of Certiorari be granted.

Dated this 18th day of January, 2007.

Respectfully submitted,

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Attorney for Petitioners

APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

No. 05-1148, No. 05-1150

[Filed October 23, 2006]

MANDY R., by and through her parents and guardians, Mr. and Mrs. R.; LISA W., by and through her parents and next friends, Mr. and Mrs. W.; STEPHANIE F., by and through her parents and next friends, Mr. and Mrs. F.,
Plaintiffs,

MARIAN L., by and through her parent and guardian, Ms. L.; JODI F., by and through her parents and next friends, Mr. and Mrs. F.; and CATHY G., by and through her parent and guardian, Russell G.,
Plaintiffs-Intervenors,

and

COLORADO ASSOCIATION OF COMMUNITY CENTERED BOARDS,
Plaintiff-Intervenor - Appellant,

v.

BILL OWENS, Governor of the State of

Colorado; MARVA HAMMONS, Executive Director of the Colorado Department of Human Services; KAREN REINERTSON, Executive Director of the Colorado Department of Health Care Policy and Financing; COLORADO DEPARTMENT OF HUMAN SERVICES; COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING,
Defendants - Appellees.

MANDY R., by and through her parents and guardians, Mr. and Mrs. R.; STEPHANIE F., by and through her parents and next friends, Mr. and Mrs. F.,
Plaintiffs - Appellants,

JODI F., by and through her parents and next friends, Mr. and Mrs. F.; MARIAN L., by and through her parent and guardian, Ms. L.; CATHY G., by and through her parent and guardian, Russell G.,
Plaintiffs-Intervenors Appellants,

and

LISA W., by and through her parents and next friends, Mr. and Mrs. W.,
Plaintiff,

COLORADO ASSOCIATION OF COMMUNITY CENTERED BOARDS,
Plaintiff-Intervenor,

v.

BILL OWENS, Governor of the State of Colorado; MARVA HAMMONS, Executive Director of the Colorado Department of Human Services; KAREN REINERTSON, Executive Director of the Colorado Department of Health Care Policy and Financing; COLORADO DEPARTMENT OF HUMAN SERVICES; COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING,

Defendants - Appellees.

Before **MURPHY**, **McCONNELL**, and **BALDOCK**, Circuit Judges.

ORDER

Appellants' petition for rehearing is denied.

The petition for rehearing en banc was transmitted to all of the judges of the court who are in regular active service. As no member of the panel and no judge in regular active service on the court requested that the court be polled, that petition is also denied.

Entered for the Court
ELISABETH A. SHUMAKER, Clerk

by: /s/ Audrey F. Weigel
Deputy Clerk

APPENDIX B

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT

No. 05-1148, No. 05-1150

[Filed September 21, 2006]

MANDY R., by and through her parents and guardians, Mr. and Mrs. R.; LISA W., by and through her parents and next friends, Mr. and Mrs. W.; STEPHANIE F., by and through her parents and next friends, Mr. and Mrs. F.,
Plaintiffs,

MARIAN L., by and through her parent and guardian, Ms. L.; JODI F., by and through her parents and next friends, Mr. and Mrs. F.; and CATHY G., by and through her parent and guardian, Russell G.,
Plaintiffs-Intervenors,

and

COLORADO ASSOCIATION OF COMMUNITY CENTERED BOARDS,
Plaintiff-Intervenor - Appellant,

v.

BILL OWENS, Governor of the State of

Colorado; MARVA HAMMONS, Executive Director of the Colorado Department of Human Services; KAREN REINERTSON, Executive Director of the Colorado Department of Health Care Policy and Financing; COLORADO DEPARTMENT OF HUMAN SERVICES; COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING,
Defendants - Appellees.

MANDY R., by and through her parents and guardians, Mr. and Mrs. R.; STEPHANIE F., by and through her parents and next friends, Mr. and Mrs. F.,
Plaintiffs - Appellants,

JODI F., by and through her parents and next friends, Mr. and Mrs. F.; MARIAN L., by and through her parent and guardian, Ms. L.; CATHY G., by and through her parent and guardian, Russell G.,
Plaintiffs-Intervenors Appellants,

and

LISA W., by and through her parents and next friends, Mr. and Mrs. W.,
Plaintiff,

COLORADO ASSOCIATION OF COMMUNITY CENTERED BOARDS,
Plaintiff-Intervenor,

v.

BILL OWENS, Governor of the State of Colorado; MARVA HAMMONS, Executive Director of the Colorado Department of Human Services; KAREN REINERTSON, Executive Director of the Colorado Department of Health Care Policy and Financing; COLORADO DEPARTMENT OF HUMAN SERVICES; COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING,

Defendants - Appellees.

Appeal from the United States District Court
for the District of Colorado
(D.C. No. 00-M-1609)

R. Eric Solem, of Solem, Mack & Steinhoff, P.C., Englewood, Colorado for Appellants.

Richard Westfall, of Hale Friesen, LLP, Denver, Colorado, for Appellant Colorado Association of Community Centered Boards.

Wade S. Livingston, First Assistant Attorney General, Human Services Unit of the State Services Section, Denver, Colorado (Attorney General John W. Suthers with him on the brief), for Appellees.

Before **MURPHY**, **McCONNELL**, and **BALDOCK**, Circuit Judges.

McCONNELL, Circuit Judge.

OPINION

Colorado has a waiting list of hundreds of developmentally disabled persons who need but do not receive Medicaid-funded services. Six such persons and an association of providers brought this suit under 42 U.S.C. § 1983, claiming that the State of Colorado has failed to comply with three requirements of the Medicaid Act, namely reasonable promptness, comparability, and sufficient payments. After a bench trial, the district court entered judgment for the Defendants. We hold that the reasonable promptness and comparability requirements do not require the State to provide services, and that neither recipients nor providers have a private right to enforce the sufficient payments requirement through § 1983. We therefore **AFFIRM**.

I. Factual and Procedural Background

This suit was brought in August 2000 by six persons, through their parents and guardians, against the governor of Colorado and two other state officials. The six individual plaintiffs are developmentally disabled persons who are on waiting lists for comprehensive residential services. These services are provided by public and private entities, which are paid by the State, which is in turn reimbursed for about half of the costs by the federal government through Medicaid. *See* 42 U.S.C. § 1396a. The State offers two kinds of Medicaid-funded services relevant to this suit. An Intermediate Care Facility for the Mentally Retarded (ICF/MR) is an institutional setting, usually large, and is "generally reserved for persons with extreme needs." Appellees' Answer Br. 5. Three such facilities exist in Colorado, and they serve about 86 persons. Two of these facilities are managed by the State, and one is operated by a private organization. The State also provides Home and Community-Based Services (HCBS). In an HCBS setting, developmentally disabled persons live "in either a small host home (serving 1 to 3 people) or slightly

larger group homes (serving 4 to 8 people)." *Id.* at 9. Over the last quarter-century the State has shifted its emphasis from ICFs/MR to HCBS, which are less expensive and less isolating.

Home and Community-Based Services are "waiver programs," which means that the State may offer them only after securing a waiver of certain Medicaid requirements from the federal government. They are also capped by the state's waiver application wherein a state must indicate the maximum number of participants it will accept in its waiver program. At the time of trial nearly 3,800 persons received HCB services. Another 733 persons wished to receive HCB services, but the services were unavailable. Roughly half of these 733 persons received no state services of any kind for the developmentally disabled. At the time of trial, only 21 persons were seeking ICF/MR services. The plaintiffs sought ICF/MR services, and each contended that the needed services were unavailable because the State refused to comply with federal law.

In October 2000, the Colorado Association of Community Centered Boards (CACCB) moved to intervene on the side of the plaintiffs. Community-centered boards are HCBS providers offering housing and medical care to the developmentally disabled and receiving, in return, Medicaid payments from the state.

Suing under 42 U.S.C. § 1983, the plaintiffs and intervenor alleged violations of the federal Medicaid Act, specifically that the State failed to provide the developmentally disabled with comprehensive residential services that meet the statutory requirements of reasonable promptness and comparability, which are described below. The individual plaintiffs sought a declaratory judgment and an injunction that would compel the state to meet the statute's

requirements, but they did not and do not ask the courts to specify the way in which the State should comply with the statute. The individual plaintiffs sought class certification on behalf of all developmentally disabled persons in Colorado who remain on waiting lists to receive comprehensive medical services. Although opposing class certification, the CACCB generally supported the individual plaintiffs' claim. The CACCB also claimed that the State pays for Medicaid services for the developmentally disabled at rates that are too low to meet the statutory requirement of sufficient payments.

The district court denied class certification and, after a four-day trial, entered judgment for the Defendants. The plaintiffs now appeal.[1]

II. Reasonable Promptness and Comparability

We begin with the claim that the State has failed to comply with the requirements of reasonable promptness and comparability. If a state chooses to participate in Medicaid, it must submit a state plan for providing "medical assistance." 42 U.S.C. § 1396a(a). The Medicaid Act imposes a number of conditions on a state plan, two of which are at issue in this case. The first is that medical assistance "shall be furnished with reasonable promptness to all eligible individuals." *Id.* § 1396a(a)(8). The second, the comparability requirement, is that the assistance any patient receives "shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual." *Id.* § 1396a(a)(10)(B)(i).

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[1] One individual plaintiff began receiving the needed services shortly before trial. She does not appeal.

In addressing these claims, we assume that the individual plaintiffs may sue to enforce their rights under subsections (8) and (10). Since the Supreme Court clarified when a statute creates an enforceable private right in *Gonzaga University v. Doe*, 536 U.S. 273, 122 S. Ct. 2268, 153 L. Ed. 2d 309 (2002), several circuit courts have considered whether one or both of these subsections creates an enforceable private right. Each has concluded that the provision in question does. *See, e.g.*, *Watson v. Weeks*, 436 F.3d 1152, 1159 & n.8 (9th Cir. 2006) (following the five federal circuit courts that have found a private right to sue for enforcement of § 1396a(a)(10), two of which did so after *Gonzaga*); *Sabree v. Richman*, 367 F.3d 180, 192 (3d Cir. 2004) (finding that each provision created an enforceable private right). *But see Sanders ex rel. Rayl v. Kan. Dep't of Soc. and Rehab. Servs.*, 317 F. Supp. 2d 1233, 1250 (D. Kan. 2004) (concluding that subsection (8) does not create an enforceable private right but finding it "a closer question" than for some Medicaid provisions); *M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1307 (D. Utah 2003) (concluding that subsection (8) does not create an enforceable private right). In this case, the district court did not clearly decide whether this portion of the statute creates a federal right enforceable under § 1983, but the parties have not disputed the point. We therefore assume without deciding that § 1983 gives the plaintiffs a right of action to enforce subsections (8) and (10). *See Burks v. Lasker*, 441 U.S. 471, 475-76, 99 S. Ct. 1831, 60 L. Ed. 2d 404 & n.5 (1979) ("The question whether a cause of action exists is not a question of jurisdiction, and therefore may be assumed without being decided.").

On the merits, the plaintiffs' reasonable promptness and comparability claims are two ways of characterizing one problem: that the individual plaintiffs are not receiving the comprehensive residential services they need. They are thus

(1) not receiving them promptly and (2) not receiving them to the extent that others receive them. The outcome of both claims turns on the same question: What is the "medical assistance" that the State must provide promptly and equally?

The Medicaid Act defines "medical assistance" as "payment of part or all of the cost of the [described] care and services." 42 U.S.C. § 1396d(a). The statutory definition mentions payment for, but not provision of, services. In other words, "the statutory reference to 'assistance' appears to have reference to *financial* assistance rather than to actual medical *services*." *Bruggeman ex rel. Bruggeman v. Blagojevich*, 324 F.3d 906, 910 (7th Cir. 2003); *see also Westside Mothers v. Olszewski*, 454 F.3d 532, 540 (6th Cir. 2006) (concluding that 42 U.S.C. §§ 1396a(a)(8) and (10) do not "require the State to provide medical services directly" but rather require only financial assistance).[2] On its face, then, the Medicaid Act requires any state participating in Medicaid to pay promptly and evenhandedly for medical services when the state is presented with the bill. If that is all the statute requires, then

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[2] Some courts have suggested that there exists a circuit split on the question of whether "medical assistance" requires a state to provide actual services. *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 181 n.1 (3d Cir. 2004); *Westside Mothers*, 454 F.3d at 540. The existence of such a split is not entirely clear. Two circuits have held that "medical assistance" requires only financial assistance. *See Bruggeman*, 324 F.3d at 910; *Westside Mothers*, 454 F.3d at 540. Another circuit has reserved the question. *Sabree*, 367 F.3d at 181. Without expressly addressing the issue, two other circuits appear to have treated the statute as requiring the provision of actual services. *Bryson v. Shumway*, 308 F.3d 79, 81, 88-89 (1st Cir. 2002); *Doe v. Chiles*, 136 F.3d 709, 714, 717 (11th Cir. 1998).

the plaintiffs have no claim: they are on a waiting list for services, not a waiting list for payment for services.

The plaintiffs offer two reasons we should reject the natural reading of the statute. The first is that the definition of "medical assistance," when read in context, requires the State to provide actual services and not merely to pay for them. The plaintiffs point to five contextual clues that "medical assistance" means actual services and not just financial payments. None of these clues, however, is sufficiently convincing to depart from the statutory definition of "medical assistance."

First, the plaintiffs point to another provision in the Medicaid Act, 42 U.S.C. § 1396a(a)(2), which requires the State to "assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services available under the plan." But this requirement explicitly controls the method of "*financial* participation by the State." *Id.* (emphasis added). The State must ensure that the non-federal portion of an eligible patient's bill is paid, by picking up any slack from "local sources" of funding, but this provision says nothing about providing the services themselves.

Second, the plaintiffs suggest that the comparability provision requires the State to provide actual services because the "medical assistance" must be the same "in amount, duration, or scope." 42 U.S.C. § 1396a(a)(10)(B)(i). The words of this provision, however, can apply to the payment for services no less logically than to the provision of services. It is coherent, and consistent with the text of the comparability provision, to require states to pay for services on a comparable basis–in the same amounts, for the same duration, and in the same scope. Accordingly, this provision does not

indicate which meaning we should give to "medical assistance," and it thus gives us no reason to depart from the general statutory definition for the Medicaid Act.

Third, the plaintiffs suggest that the State must provide services whenever necessary to assure that "care and services will be provided[] in a manner consistent with simplicity of administration and the best interests of the recipients." 42 U.S.C. § 1396a(a)(19). The plaintiffs give scant attention to this argument, and for good reason. In *Bruggeman* the Seventh Circuit held that this provision was "insufficiently definite to be justiciable, and in addition cannot be interpreted to create a private right of action." *Bruggeman*, 324 F.3d at 911 (citing three other circuits that have reached the same conclusion, under the Medicaid Act or under § 1983). We need not reach the private-right-of-action question, which is not before us, to determine that this provision does not require the State to provide actual services. If this provision implicitly required the State to provide services, because it is something in the "best interests of the recipients," we see no logical end. Without a logical stopping point or anything more definite than "best interests," we do not read this provision to require the State to provide actual services.

Fourth, the plaintiffs point to the plan the State filed with the federal government, which promised to provide ICFs/MR with "No Limitations." Colorado State Medicaid Plan, R. Vol. IV, at 755. This phrase appears in the state plan on a page titled "Amount, Duration and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy." *Id.* A series of services are mentioned, from ICFs/MR to nurse-midwife services, and for each the government checked boxes indicating that the services are provided with "No Limitations, " are provided "With Limitations," or are "Not Provided." *Id.* As the director of

the State's Medical Assistance Office explained, "limitations" are limits on payments to otherwise eligible patients, such as the limit that the State will pay for only 45 days of in-patient psychiatric services in a calendar year. R. Vol. II, at 350. If the State wishes to enforce such a limit on the provided services it will pay for, it must announce the limit in the state plan. By choosing "No Limitations," the State was abjuring limits such as the length of ICF/MR services for which it would pay, but there is no indication that by checking this box the State promised to build, staff, and maintain as many ICFs/MR as would be needed to meet the demand in Colorado.

Fifth, the plaintiffs assert that Colorado's waiver application indicates a commitment to ensuring that every eligible patient receives services, either from ICFs/MR or HCBS. The waiver application provides that a developmentally disabled adult deemed to require the level of care offered by an ICF/MR will be "informed of any feasible alternatives" to ICFs/MR and "[g]iven the choice of either institutional or home and community-based services. " R. Vol. IV, at 863. Although the waiver application suggests that a developmentally disabled person will have a choice between an ICF/MR and HCBS, it does not assign to the State, or any other party, the responsibility to ensure that such facilities are in fact available. Indeed, the waiver application appears to mean only that the choice among "feasible alternatives" is to be made by the recipient - not that the State must make alternatives available. Because it is at best ambiguous on the point, it provides no reason to reject the natural reading of the statutory definition. None of these five contextual clues, therefore, undermines the statutory definition of "medical assistance" as payment for services.

The plaintiffs' second reason to reject the payment-only reading of "medical assistance" is policy based. The plaintiffs accuse the State of promising to pay for services for the developmentally disabled and then suppressing the supply of these services. They are effectively asking us, in the alternative, (1) to conclude that in the context of the Medicaid Act, the state plan, and the State's waiver application, "medical assistance" includes a requirement that the State be a service-provider of the last resort; or (2) to graft onto "medical assistance" a good-faith requirement that would oblige the state not to discourage proposals from outside care providers. Such a good-faith requirement has intuitive appeal, for the State has obvious conflicts of interest. At oral argument the State even conceded that it may not escape paying for ICF/MR services by setting rates so low that no one can provide them. *Cf. Westside Mothers*, 454 F.3d at 541 (allowing plaintiffs, after amending their complaint, "to allege that inadequate payments effectively deny the right to 'medical assistance'").

Nevertheless, we need not decide whether a state has (or may assume) a good-faith obligation not to prevent new entrants into this market. The precise claim brought by the plaintiffs is narrow. The plaintiffs do not suggest that ICF/MR rates have been set so low as to prohibit new entrants to the market. Nor do the plaintiffs claim that the State has discouraged efforts to build HCBS facilities, which is where the greatest shortfall in facilities exists. And the plaintiffs do not claim that the state has denied or effectively denied (through delay or similar means) a formal application to build new ICF/MR facilities. Indeed, the plaintiffs could not claim this, because no such applications have been filed. Instead, the individual plaintiffs claim that the State has discouraged efforts to build new ICFs/MR by responding cooly to initial inquiries. This is too nebulous a basis to support a legal

claim. It is the State's prerogative to prefer HCBS over ICFs/MR - a preference shared by many advocates for the developmentally disabled - and to make that policy preference known. Assuming *arguendo* that the State has a duty (either statutory or self-imposed) not to prevent new entrants who could provide ICF/MR services, it violated no such duty here, where it neither rejected nor was even presented with any formal applications. If a case arises in which the State has effectively prevented a qualified provider of ICF/MR services from entering the market, we will have to decide whether such a good-faith requirement exists.

We therefore agree with the Sixth and Seventh Circuits that the Medicaid statute does not require states to be service-providers of last resort. *See Westside Mothers*, 454 F.3d at 540; *Bruggeman*, 324 F.3d at 910. Although *Bruggeman* concerned a claim about the location of ICFs/MR within a state, and not about the lack of them, the Seventh Circuit's conclusion is directly on point and persuasive:

> Medicaid is a payment scheme, not a scheme for state-provided medical assistance, as through state-owned hospitals. The regulations that implement the provision indicate that what is required is a prompt determination of eligibility and prompt provision of funds to eligible individuals to enable them to obtain the covered medical services that they need . . .; a requirement of prompt *treatment* would amount to a direct regulation of medical services.

Bruggeman, 324 F.3d at 910. The State must pay for medical services, but it need not provide them.

III. Rates

A second claim is brought only by the CACCB: that the State payments for waiver services (HCBS) are insufficient to comply with the Medicaid Act. Specifically, the CACCB claims that the rates at which the State pays for waiver services violate 42 U.S.C. § 1396a(a)(30)(A), which requires a state to

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a)(30)(A). CACCB brings this claim not only for itself, as an association of providers, but also on behalf of recipients generally (though not on behalf of the six individual plaintiffs). Before we can reach the merits of the claim, we must decide whether subsection (30)(A) creates a private right enforceable under § 1983. Section 1983 imposes liability on anyone who, under color of state law, deprives a person "of any rights, privileges, or immunities secured by the Constitution and laws." To seek redress through § 1983, a plaintiff must assert a violation of a federal right, not merely a violation of federal law. *Blessing v. Freestone*, 520 U.S. 329, 340, 117 S. Ct. 1353, 137 L. Ed. 2d 569 (1997). The Court has set forth three criteria necessary to finding that a statutory provision gives rise to a federal right:

> First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States. In other words, the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms.

Id. at 340-41 (citations omitted). Once a plaintiff demonstrates that a statute creates a federal right, the right is presumptively enforceable under § 1983 unless Congress specifically foreclosed such a remedy. *Gonzaga*, 536 U.S. at 284 & n.4.

In *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 110 S. Ct. 2510, 110 L. Ed. 2d 455 (1990) the Supreme Court considered a Medicaid provision with wording very similar to subsection (30)(A), and the Court did find an enforceable private right.[3] In *Gonzaga*, 536 U.S. at 283, however, the

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[3] The statute, which was known as the Boren Amendment and has since been repealed, was the previous version of 42 U.S.C. § 1902(a)(13). It read as follows:

> a State plan for medical assistance must-
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> . . . . .
>
> provide . . . for payment . . . of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State . . .) *which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities* in order to provide care

Supreme Court tightened the first requirement. After *Gonzaga*, an enforceable private right exists only if the statute contains nothing "short of an unambiguously conferred right" and not merely a vague benefit or interest. *Id.* No enforceable right exists "where a statute by its terms grants no private rights to any identifiable class." *Id.* at 283-84. Although professing not to overrule *Wilder*, *Gonzaga* recharacterized the earlier decision as a case finding an enforceable private right in a "provision [that] required States to pay an 'objective' monetary entitlement to individual heath care providers." *See Gonzaga*, 536 U.S. at 280; *see also id.* at 300 n.8 (Stevens, J., dissenting).

Since *Gonzaga*, four circuit courts have considered whether subsection (30)(A) creates an enforceable private right. Three have concluded that the provision does not create an enforceable right. *Westside Mothers v. Olszewski*, 454 F.3d 532, 542-43 (6th Cir. 2006) (concluding that subsection (30)(A) "has an aggregate focus rather than an individual focus" and its "broad and nonspecific" language is "ill-suited to judicial remedy"); *Sanchez v. Johnson*, 416 F.3d 1051, 1059 (9th Cir. 2005) (finding no enforceable private right for recipients or providers because "nothing in the text of § 30(A) . . . unmistakably focuses on recipients or providers as individuals" and because "the flexible, administrative standards embodied in the statute do not reflect a

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> and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality.

42 U.S.C. § 1396a(a)(13)(A) (1982 ed., Supp. V), quoted in *Wilder*, 496 U.S. at 502-03 (emphasis in quotation).

Congressional intent to provide a private remedy for their violation"); *Long Term Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 57 (1st Cir. 2004) (finding no enforceable private right for providers because subsection (30)(A) "has no 'rights creating language' and identifies no discrete class of beneficiaries"). Only one circuit has found an enforceable private right. *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 443 F.3d 1005, 1015-16 (8th Cir. 2006) (following prior circuit precedent that subsection (30)(A) created an enforceable private right for recipients and providers, and concluding that even after *Gonzaga* the provision "creates enforceable rights for both groups").

We join the First, Sixth, and Ninth Circuits in concluding that subsection (30)(A) does not create a federal right enforceable under § 1983. Even though *Wilder* addressed a similar statute, our approach is controlled by *Gonzaga*, the Supreme Court's most recent assessment of private rights of action. Applying that analysis, we conclude that subsection (30)(A) "identifies no discrete class of beneficiaries." *Long Term Health Care Pharmacy Alliance*, 362 F.3d at 57. This provision refers to recipients only "in the aggregate, as members of 'the general population in the geographic area'"; and providers are mentioned only "as indirect beneficiaries 'enlisted' as subordinate partners in the administration of Medicaid services." *Westside Mothers*, 454 F.3d at 542-43 (quoting 42 U.S.C. § 1396a(a)(30)(A)). Recipients and providers surely benefit from efficient Medicaid administration, for example, as do taxpayers generally, but subsection (30)(A) never establishes an "identifiable class" of rights-holders. And without such an identifiable class, no enforceable federal right is created. *Gonzaga*, 536 U.S. at 283-84.

Because subsection (30)(A) fails to satisfy the first of the criteria set forth in *Blessing* for establishing a federal right enforceable under § 1983, there is no need for us to consider the other criteria. See *Gonzaga*, 536 U.S. at 287-89 (holding that certain provisions of federal law are not privately enforceable under § 1983 because there was no congressional intent to confer rights on individual beneficiaries, without consideration of other *Blessing* factors); *cf. id.* at 292 (Breyer, J., concurring) (agreeing with the majority but also concluding that "[m]uch of the statute's key language is broad and nonspecific").

One circuit has found that subsection (30)(A) creates an enforceable private right. Relying on its own precedent, *Wilder*, and *Gonzaga*, the Eighth Circuit found that both recipients and providers could sue to enforce this subsection. *Pediatric Specialty Care*, 443 F.3d at 1015-16. In analyzing *Gonzaga*, the court concluded that "[t]he beneficiaries [of subsection (30)(A)] are both the recipients of the services and the recipients of the state's payment," i.e., the providers. *Id.* at 1015. We respectfully disagree. Despite the fact that recipients and providers ultimately benefit from competent administration, they are nowhere identified in the statutory provision as a class of beneficiaries. And *Gonzaga* requires not a vague benefit or interest but rather an "unambiguously conferred right." 536 U.S. at 283. In sum, because the provision does not confer enforceable federal rights on identified beneficiaries, *Gonzaga* precludes interpreting subsection (30)(A) to create a federal right enforceable under § 1983.

IV. Class Certification

Finally, the plaintiffs also challenge the district court's denial of class certification. Because this opinion disposes of

all issues in the potential class action, plaintiffs' motion for class certification is now moot. *See Gullickson v. Sw. Airlines Pilot's Ass'n*, 87 F.3d 1176, 1187 (10th Cir. 1996); *Rucker v. St. Louis Sw. Ry. Co.*, 917 F.2d 1233, 1237 n.1 (10th Cir. 1990).

V. Conclusion

For the foregoing reasons, we **AFFIRM** the district court's entry of judgment in favor of the defendants.

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO
Senior District Judge Richard P. Matsch

Civil Action No. 00-M-1609

[Filed March 1, 2005]

MANDY R., by and through her parents and guardians, Mr. and Mrs. R.; LISA W., by and through her parents and next friends, Mr. and Mrs. W.; STEPHANIE F., by and through her parents and next friends, Mr. and Mrs. F.,
Plaintiffs,

MARIAN L., by and through her parent and guardian, Ms. L.; JODI F., by and through her parents and next friends, Mr. and Mrs. F.; and CATHY G., by and through her parent and guardian, Russell G.,
Intervenor-Plaintiffs, and

COLORADO ASSOCIATION OF COMMUNITY CENTERED BOARDS,
Intervenor-Plaintiff,

v.

BILL OWENS, Governor of the State of Colorado; MARVA HAMMONS, Executive

Director of the Colorado Department of Human Services; KAREN REINERTSON, Executive Director of the Colorado Department of Health Care Policy and Financing; COLORADO DEPARTMENT OF HUMAN SERVICES; COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING,

Defendants.

JUDGMENT

Pursuant to the memorandum opinion and order entered by Senior District Judge Richard P. Matsch on February 28, 2005, it is

ORDERED AND ADJUDGED that the claims of the plaintiffs and intervenor-plaintiffs are dismissed. Pursuant to D.C.COLO.L.R. 54.1, the defendant will be awarded costs upon the filing of a bill of costs within ten days after entry of this judgment.

DATED: March 1, 2005

GREGORY C. LANGHAM, Clerk

By /s/ _____
Deputy Clerk

APPENDIX D

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLORADO
Senior District Judge Richard P. Matsch

Civil Action No. 00-M-1609

[Filed February 28, 2005]

MANDY R., by and through her parents and guardians, Mr. and Mrs. R.; LISA W., by and through her parents and next friends, Mr. and Mrs. W.; STEPHANIE F., by and through her parents and next friends, Mr. and Mrs. F., CATHY G., by and through her parent and guardian, Russell G., MARIAN L., by and through her parent and guardian, Ms. L.; JODI F., by and through her parents and next friends, Mr. and Mrs. F.; and
Intervenor-Plaintiffs, and

COLORADO ASSOCIATION OF COMMUNITY CENTERED BOARDS,
Intervenor-Plaintiff,

v.

BILL OWENS, Governor of the State of Colorado; MARVA HAMMONS, Executive Director of the Colorado Department of Human Services; KAREN REINERTSON, Executive

Director of the Colorado Department of Health Care Policy and Financing; COLORADO DEPARTMENT OF HUMAN SERVICES; and COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING,
Defendants.

MEMORANDUM OPINION AND ORDER

Matsch, Senior District Judge

The plaintiffs in this action are adults who suffer from developmental disabilities ("DD"). Their parents and guardians have brought this civil action on their behalf against defendant Bill Owens in his capacity as the Governor of Colorado, Marva Hammons in her capacity as the director of the Colorado Department of Human Services ("DHS"), and Karen Reinedson in her capacity as the director of the Colorado Department of Health Care Policy and Financing ("HCPF") (collectively the "State Defendants"), claiming that the State of Colorado is violating its obligations under Title XIX of the Social Security Act of 1965, 42 U.S.C. § 1396a, *et seq.* (the "Medicaid Act"), by falling to provide appropriate 24-hour residential care and treatment to all developmentally disabled adults in Colorado eligible for Medicaid-funded care. The findings of fact and conclusions of law required by Fed. R. Civ. P. 52 from the trial are contained in this memorandum.

Colorado Association of Community Centered Boards ("CACCB") intervened on behalf of the non-profit organizations who deliver DD services under contract with the State, claiming that the reimbursement rates have been and now are too low to provide adequate incentives to the

development of new care facilities and to assure the quality of care to which Medicaid recipients are entitled.

The Medicaid Act

Congress enacted the Medicaid Act as a means for public funding of the cost of providing medical assistance to persons unable to pay for it. Medicaid is a joint program with states who elect to participate in it. Under Medicaid, a state pays providers of medical services and receives reimbursement from the national government of a percentage of those payments. To participate in the Medicaid program, a state must adopt a State Plan that complies with statutory requirements and imprementing regulations of the Secretary of Health and Human Services ("HHS"). The Centers for Medicare and Medicaid Services ("CMS") (formerly known as the Health Care Financing Administration) is the agency within HHS responsible for administration of Medicaid, including approval of State Plans and monitoring their operations.

Each participating state determines who is eligible for medical assistance, the types of assistance to be paid for and the rates of reimbursement. The State Plans must include some specified categories of eligible persons and some types of medical assistance mandated by the federal law, with the option to include more categories of eligibility and additional services. Thus, the states have complete freedom to choose whether they will join the program and some discretion to determine the levels of participation.

Care for mentally retarded persons in a facility designated as an Intermediate Care Facility for the Mentally Retarded ("ICF/MR") is an optional service under Medicaid. *See* 42 U.S.C. §§ 1396a(1)(10)(A) and 1396d(a)(15). ICF/MRs are

institutional care facilities subject to extensive federal regulation. *See* 42 CFR Part 483, Subpart I.

The Medicaid Act requires that medical assistance provided under a State Plan be furnished with "reasonable promptness" to all eligible individuals and that the assistance provided to any one group be comparable to that provided to other groups. The Act authorizes a waiver of certain statutory requirements to enable states to provide coverage for specialized services. One such waiver is an array of home and community-based services ("HCBS") to persons who would otherwise need care in a skilled nursing facility ("SNF"), an ICF/MR, or a similar institution. 42 U.S.C. § 1396n(c); 42 C.F.R. 441.300. These services are typically provided in private homes or apartments, group homes, or host homes. These alternatives to institutional care may be more beneficial to the recipients and may be less costly than institutional care. Waivers for HCBS services are granted only upon assurances and conditions satisfactory to CMS. *See* 42 U.S.C. § 1396n(c)(2). To obtain a waiver, a state must provide an estimate of the number of persons expected to receive services and the estimate becomes a cap for spending on the waiver program. The cap must be no fewer than 200 recipients of such services. *See* 42 U.S.C. § 1396n(c)(9) and (10); 42 C.F.R. § 441.303(f)(6).

Colorado's State Plan and Delivery of DD Services

The Colorado General Assembly enacted the Colorado Medicaid Assistance Act, C.R.S. § 26-4-101, *et seq.*, authorizing participation in Medicaid. Colorado has adopted a State Medicaid Plan (the "State Plan"). CMS has approved Colorado's State Plan and federal funds have been provided pursuant to it.

Colorado included ICF/MR services in its State Plan. C.R.S. § 26-4-302(1)(I). Colorado obtained a Medicaid waiver to include HCBS services to individuals with DD who otherwise would require services in an ICF/MR. (Ex. A-1), The HCBS-DD waiver permits payment for full time residential services for adults with DD (over 18 years of age) in host homes (serving 1 to 3 persons) or in group homes (serving 4 to 8 people). Colorado also obtained a Medicaid waiver to provide Supported Living Services ("SLS") to persons with DD. The SLS program, as the name implies, provides financial support for assistance to people who live in their own homes or in their parents' homes, in amounts less than the cost of full time residential care. The Colorado State Plan includes other Medicaid-funded services to persons with DD that are not included in this case.

The Medicaid Act requires each state to designate a single state agency to be responsible for administration of the state's Medicaid program. In Colorado, HCPF is designated as that agency. It has an interagency agreement with defendant DHS for the administration of Medicaid-funded DD programs. DHS has established the Division for Developmental Disabilities for administration of community-based DD programs.

The State of Colorado owns and operates three Regional Centers providing services for developmentally disabled persons at Wheat Ridge, Grand Junction and Pueblo. *See* C.R.S. § 27-10.5-301. The Regional Centers house persons with the greatest needs, including medically fragile individuals and sex offenders. There are ICF/MR facilities at the Regional Centers at Wheat Ridge and Grand Junction. Those who are there as long term placements in the ICF/MR pads of the Regional Centers have been placed after a state

court process imposing legal disabilities. *See* C.R.S. § 27-10.5-110.

A privately owned ICF/MR, Good Shepherd, is in Littleton, Colorado, and has a capacity of 16 beds. There are no other ICF/MRs in Colorado. At the time of trial, a total of 96 persons were being served in the three ICF/MR facilities.

The delivery of DD services in Colorado is the responsibility of Community Centered Boards ("CCBs"). *See generally* C.R.S. § 27-10.5-101 - 139. They are non-profit organizations, each of which functions in one of 20 geographical regions known as "catchment areas," pursuant to contracts with the State. *See* C.R.S §§ 27-10.5-102(3); 27-10.5-103; 27-10.5-104, and 27-10.5-105. Each CCB is the point of entry in its area. The CCBs determine individual eligibility for services to be provided in accordance with individual plans matching the particular needs with appropriate services for each recipient. Generally, those services are provided by subcontractors, but in some sparsely populated rural areas the CCBs deliver services directly.

At the time of trial, approximately 3800 adults were receiving HCBS-DD services in Colorado. Most of these waiver services are provided through the CCBs, but there are group homes at the three Regional Centers serving about 300 people. The approved HCBS-DD cap for 2002-03 was 3,807. Colorado's HCBS-DD "waiver slots" have all been utilized, but they have not been adequate to serve all who are eligible for and could benefit from those services.

Because there are only three ICF/MR facilities and the HCBS-DD waiver program is at full capacity, the CCBs have waiting lists of eligible persons. The plaintiffs contend the failure to provide services to those on the waiting lists violates

42 U.S.C. § 1396a(a)(8), known as the "reasonable promptness" provision of the Medicaid Act, and 42 U.S.C. § 1396a(a)(10)(B), the "comparability" provision. The CACCB, representing the twenty CCBs, joins in that claim and adds a "rates" claim, contending that the reimbursement rates for payment by the State are so low that the quality of care is compromised in violation of 42 U.S.C. § 1396a(a)(30)(A), and that no new private care facilities can be developed without improvement of economic incentives.

There is a threshold question of jurisdiction. The core of the plaintiffs' complaint is that Colorado has defaulted in its statutory obligation to provide medical assistance to the plaintiffs who are eligible for benefits. They argue that the Medicaid Act creates an entitlement to services enforceable by a private action pursuant to 42 U.S.C. § 1983, following *Blessing v. Freestone,* 520 U.S. 329 (1997) and *Wilder v. Virginia Hosp. Ass'n,* 496 U.S. 498 (1990). The State Defendants deny that claim, citing *Gonzaga Univ. v. Doe,* 536 U.S. 273 (2002). They argue that the Medicaid Act is comparable to an insurance plan, and the State's obligation is to pay for but not provide ICF/MR services. Thus the court is asked to interpret the meaning of the Medicaid Act, a function within the jurisdiction provided by 28 U.S.C. § 1331.

There is a conflict in the views of other courts where other plaintiffs have made such claims for enforcement of an entitlement under other State Plans pursuant to 42 U.S.C. § 1983. *Compare Sabree v. Richman,* 367 F.3d 180 (3d Cir. 2004) (holding that § 1983 provides a basis for claims alleging violations of the Medicaid Act), *with M.A.C. v. Betit,* 284 F.Supp.2d 1298 (D. Utah 2003) (holding that provisions of the Medicaid Act do not contain language conferring individual rights necessary to support a cause of action under

§ 1983). *Gonzaga* makes it clear that there is no private claim for damages created by federal funding statutes for programs conducted by recipients of that funding in the absence of explicit language in the authorizing legislation. The specific issue was whether a university student could recover damages upon a claim of injury from a release of student records in violation of a prohibition in the Family Education Rights and Privacy Act. The Court interpreted the nondisclosure provisions as a required institutional policy and practice rather than providing protections of individual interests.

Gonzaga would be dispositive here if these plaintiffs sought damages caused by the failure to provide services or for individual remedies such as a mandatory injunction that each of them be provided specific benefits according to their needs. That is not this case. At the pretrial conference, this court made it clear that the only relief that could be provided would be a declaratory judgment that Colorado was not complying with the requirements for federal participation in the funding of its programs for the developmentally disabled.

Jurisdiction to consider the issues in dispute does not depend upon finding an implied private right of action; it may follow from a finding that the plaintiffs and Intervenor have standing to litigate the issues of the scope and extent of the duties undertaken by Colorado as a result of its election to participate in Medicaid.

This case began as a claim of entitlement to benefits which would require an implied cause of action for a remedy under § 1983. As it evolved from this court's orders denying certification as a class action under Fed.R.Civ.P. 23 and the State Defendants' motion for summary judgment, it developed into a case or controversy requiring interpretation of the Medicaid Act and the court's authority to act on that

interpretation. The State Defendants have implemented the State Plan in the belief that it is not required to provide funding for the development of enough capacity to care for all those who may be eligible for DD services. That reading is based on the definition of "medical assistance" in § 1396d(a) which speaks of payment of all or part of the cost of care and services. They concede that they must pay for the State's share of ICF/MR services provided to eligible persons, but deny that the State has a duty to make such services available, either directly or indirectly. In short the State of Colorado characterizes Medicaid as a health insurance program in which it and the national government are the insurers of payment.

The plaintiffs and Intervenor assert that by its election to participate in Medicaid, Colorado has undertaken an obligation to make sure that all eligible people in need actually receive the services promised to them, either by directly providing those services through state institutions or by establishing a program for reimbursement at rates that will make possible the provision of such services by non-governmental organizations.

This frames a controversy within the jurisdiction of § 1331 as a call for the interpretation of a federal statute and regulations and the possibility of a declaratory judgment under 28 U.S.C. § 2201.

The State Defendants have argued that because CMS has oversight authority over the State Plan and has not challenged the operation of the Colorado program, this court has no role to play. Congress did provide that HHS may disapprove the State Plan and withhold federal funds. Congress did not, however, explicitly say that HHS has exclusive jurisdiction to determine questions of compliance with the Medicaid Act.

Accordingly, the merits of these opposing views of the statutory language must be considered.

42 U.S.C. § 1396a(a)(8) states that a State Plan must "provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." Section 1396a(a)(10)(B) generally requires that the medical assistance provided to one group of Medicaid recipients must be not less in "amount, duration or scope" than the medical assistance provided to other groups. The plaintiffs and Intervenor offer different interpretations of these provisions. The plaintiffs contend that the State must make ICF/MR placement available to all eligible individuals needing such care, but that recipients should be able to choose whether to accept the alternative of HCBS-DD services. The individual plaintiffs do not want to be placed in large institutions. They want ICF/MR services in settings comparable to the Good Shepherd facility providing care for sixteen individuals in four buildings that look much like private homes. The CACCB joins the plaintiffs in claiming that the State must provide full-time residential services to all eligible individuals, but the Intervenor advocates the expansion of HCBS-DD and disagrees that recipients have the option to choose their placements.

The State Defendants have collected data about the waiting list. In general, the CCBs are required to report and update information about persons waiting for HCBS-DD on a monthly basis. DHS has conducted a number of surveys to verify the accuracy of this data. There is uncertainty about that data, because some people have declined to accept services when they were offered and some place their names on a waiting list before they actualty need the services because they are aware of the waiting lists.

At the time of trial, there were approximately 733 eligible persons who were waiting for and who would accept, HCBS-DD immediately. The number of people waiting for HCBS-DD has grown steadily over the last several years. The manner in which the data are collected makes it difficult to say with certainty how long people may have to wait for HCBS-DD, but one can certainly wait for years. Most people leave the waiting list and begin receiving residential services when there is an emergency situation such as the death of a parent or other caretaker.

Some individuals who are waiting for placement in a residential facility are currently receiving some other type of assistance. For example, plaintiff Stephanie F. receives SLS services in her parents' home and is on the waiting list for residential HCBS-DD care. Of the 733 persons on the waiting list, 393 are not receiving any type of DD service.

After this lawsuit was filed, DHS asked the CCBs to begin collecting data about persons who are waiting for ICF/MR placement. It was reported that only 21 persons are seeking ICF/MR services. The testimony of the plaintiffs' parents reflects a strong preference for HCBS-DD over ICF/MR. For example, the parents of Mandy R. declined an offer of ICF/MR placement. She now receives care in an HCBS-DD host home.

The plaintiffs' contention is that all eligible individuals must be given appropriate care with reasonable promptness and that HCBS-DD services must be comparable to those provided in an ICF/MR. The defendants' contention that it must pay for but not provide care is consistent with the decision of the Seventh Circuit Court of Appeals in *Bruggeman v. Blagojevich,* 324 F.3d 906 (7th Cir. 2003) where the court denied the claim of parents who sought to

require Illinois to provide ICF/MR facilities for their children near their homes in Chicago although facilities were available to them in southern Illinois. The court said, "Medicaid is a payment scheme, not a scheme for state provided-medical assistance, as through state-owned hospitals." *Id.* at 910.

Other courts have disagreed, holding that Congress intended that needy persons are entitled to adequate care, but most authority on this issue focuses on the sufficiency of the plaintiffs' complaints to state a claim rather than the form of relief that can be ordered. In *Sabree v. Richman,* 367 F.3d 180 (3d Cir. 2004) mentally retarded adults eligible and in need of ICF/MR services were permitted to maintain an action under § 1983. The United States Court of Appeals for the Third Circuit said that the reasonable promptness and comparability provisions of the Medicaid Act unambiguously conferred individual federal rights and that Congress had not precluded private enforcement. The United States Court of Appeals for the First Circuit reached the same conclusion with respect to the reasonable promptness requirement in *Bryson v. Shumway,* 308 F.3d 79 (1st Cir. 2002). *See also Martin v. Taft,* 222 F.Supp.2d 940 (S.D. Ohio 2002) (holding that plaintiffs' claims for violations of Medicaid Act's reasonable promptness, comparability, and freedom of choice provisions were actionable under § 1983).

Significantly, these cases do not address the appropriate remedy for violations of the Medicaid Act. In *Doe v. Chiles,* 136 F.3d 709 (11th Cir. 1998), the United States Court of Appeals for the Eleventh Circuit held that Medicaid's reasonable promptness provision is enforceable under § 1983, and it affirmed the district court's order grant of injunctive relief requiring Florida officials to "establish within the State's Medicaid Plan a reasonable waiting list period, not to exceed ninety days, for individuals who are eligible for

placement in ICF/DD." Subsequent litigation concerned the scope and enforcement of the injunction. *See Doe v. Bush,* 261 F.3d 1037 (11th Cir. 2001), *cert. denied sub nom. Kearney v. Does 1-13,* 534 U.S. 1104 (2002) (reversing district court's entry of an order holding state officials in contempt for failing to comply with the injunction). The history of *Doe v. Chiles* highlights the difficulties arising from a federal court's grant of injunctive relief requiring state legislative action for compliance. The federalism issues implicated by such relief deserve heightened attention in the present case because of budgetary constraints imposed by the Colorado Constitution.

When the arguments about the purpose of Medicaid are no longer abstract analyses of the statutory language but must be considered in the full context of the evidence received at this trial, the plaintiffs' and Intervenor's claims become untenable. As will be seen, a ruling in their favor would require this court to declare that Colorado must raise and spend enough money to expand DD care facilities to meet demands that are beyond its control and without the support of federal funding. The Medicaid Act does not provide for federal participation in the cost of expanding capacity for the delivery of medical care. It is clear that HHS funds can be obtained only for payment of the cost of services after they have been provided. Thus the national government is in the position of an insurer, not a provider. The level of funding for Medicaid in Colorado is determined by the Colorado General Assembly. The funds to be spent are those collected by taxation and the Colorado electorate has imposed constitutional constraints on the power of the legislature to impose taxes and the purposes for which public funds can be spent.

If the State Defendants were to expand institutional care at the Regional Centers they are at risk of violating the

mandate of the Supreme Court in *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999), holding that compliance with the Americans with Disabilities Act ("ADA") requires that mentally retarded persons be provided community-based treatment because providing for them in institutional settings would be discriminatory if in the professional judgment of treatment professionals, they can be accommodated in less restrictive settings. Such community-based treatment is provided by Colorado under the HCBS waiver program. To declare that the funding of the waiver program must be stopped and those resources made available for ICF/MR institutionalized services would cause Colorado to violate the Rehabilitation Act.

In considering *Olmstead*, it is appropriate to note that the Court recognized the limitations of its authority. Justice Ginsburg, writing for the Court, answered the question of whether the ADA requires placement of persons with mental disabilities in community settings rather than in institutions with a "qualified yes" saying:

> Such action is in order when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, *taking into account the resources available to the State and the needs of others with mental disabilities*.

527 U.S. at 587 (emphasis added). That qualification recognizes the political authority of the states in the federal system. These shared funding statutes do not abrogate the division of power between the states and the national government established in the Constitution. The political will

of the people of Colorado controls the level of taxation to fund services paid for through the agencies of the State government and they have exercised that control with recent citizen initiated amendments to the Colorado Constitution.

The services at issue in this action are optional Medicaid services. The State of Colorado could participate in Medicaid without including these services in its State Plan. The State may elect to withdraw these services from the State Plan if the financial burden is found to be burdensome.

If this court were to agree with the contention that, by accepting the benefit of partial funding of the cost of the care provided, the State must assure the delivery of adequate care for all eligible DD, it must decide Colorado has not been complying with that obligation. The State legislature has not provided enough money to build and staff enough ICF/MR facilities to meet existing demand and there has been a diversion away from ICF/MR care in the existing state institutions in favor of HCBS services because they are less costly and because such services are thought to be more effective, as well as required by *Olmstead*.

The plaintiffs' reading of the Medicaid Act would place it in the category of unfunded mandates, raising serious questions of constitutionality of the power of the national government to use the infusion of funding to compel unlimited financial obligations on the states in the federal system. Medicaid has been characterized as a shared program but the sharing is disproportionate if the State is obliged to provide as well as pay for these services. If Colorado were to respond immediately to the plaintiffs' claims, it would be required to take the HCBS programs out of the Regional Centers and re-institutionalize those facilities, contrary to the obligation to provide care in the most integrated and least restricted setting

available to the needs of individual DD's as required by *Olmstead*.

For these reasons, this court cannot order the State to provide any particular level of ICF/MR services or to continue them in its State Plan. Nor do the claims directed to the State's administration of the HCBS-DD program provide a basis for relief. Federal law permits the comparability requirement to be waived with respect to services provided under an HCBS waiver. Colorado has obtained a waiver of that requirement. Relevant Medicaid statutes and regulations also authorize a limit on the number of individuals to receive home and community-based, services pursuant to a waiver. 42 U.S.C. § 1396n(c)(9) and (10); 42 C F.R. § 441.303(f)(6). The limit is based on the State's estimate of unduplicated beneficiaries" to be served each year, known as the "C-factor." The C-factor is not an absolute cap; CMS permits some deviation from this number – approximately 10% – without requiring amendment of the waiver application. The fact remains that the capacity of Colorado's HCBS-DD program is limited. Under Colorado law the utilization of public funds for HCBS-DD is "subject to appropriation." C.R.S. § 26-4-624(1.5). Expenditures cannot exceed the Colorado legislature's annual appropriation of funds for the program.

The Intervenor's Rates Claim

The Intervenor claims that Colorado's administration of its State Plan violates 42 U.S.C. § 1396a(a)(30)(A), providing that a State Plan must:

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to

> safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area: ....

This claim focuses on the rates paid by the State to the CCBs.

CCBs are recognized as "Organized Health Care Delivery Systems," allowing them to receive Medicaid payments. *See* 42 C.F.R. § 447.10. CCBs are paid an overall rate to provide services to eligible persons in their catchment areas. The CCBs, in turn, either provide the services themselves or negotiate rates with subcontractors.

The level of funding provided by the State results in community service providers *(i.e.*, providers paid through the CCBs) being unable to pay their workers amounts that are comparable to employees working in the State-operated Regional Centers. The CCBs and their subcontractors have experienced high employee turnover rates and difficulties in recruiting, training and retaining qualified staff.

DHS has advocated for increases in rates for CCBs for many years. In part, DHS has urged that the rates be increased in order to increase the wages of direct care providers, making it easier to recruit and retain such providers. The Colorado General Assembly has not increased these rates by nearly as much as DHS has asked. The rates paid to CCBs have not kept up with inflation. As a result, some CCBs have reduced the amount of services they provide to persons with DD.

The Intervenor claims that the rates paid by Colorado to service providers through the CCBs are so low that Medicaid recipients are being deprived of access to services and quality care. Intervenor seeks a determination that the rates paid by the State for HCBS-DD services fall "outside any reasonable definition of efficiency and economy, quality of care and/or access to services." (Intervenor's Proposed Findings of Fact, at ¶ 67).

The evidence presented does not provide a basis for determining what level of funding is consistent with "quality of care" or that the present level of funding falls below the standard expressed in 42 U.S.C. § 1396a(a)(30)(A). CCB designation depends upon, *inter alia,* "the [q]uality of services and supports provided directly or by contract for persons with developmental disabilities. C.R.S. § 27-10.5-05(1)(d). The Colorado Department of Public Health and Environment performs inspections and evaluates the quality of care performed in ICF/MR facilities and HCBS-DD, facilities. No evidence was presented of widespread compliance problems among community providers.

The Intervenor bases its request largely on statistical evidence previously presented to the Colorado General Assembly's Joint Budget Committee. In effect, the intervenor is asking this court to substitute its judgment for that of the Colorado legislature. As described above, the Colorado Constitution restricts the spending authority of the Colorado legislature. The Colorado legislature has determined how to allocate the State's limited resources and how to balance the competing needs of state-funded programs in light of those restrictions. The record in this action does not provide a basis for this court to override the policy decisions of that body, and indeed such an exercise of federal judicial authority would encroach upon fundamental powers of the State government.

The relief proposed by the plaintiffs and Intervenor would pose insurmountable problems of enforcement. The plaintiffs request that this court order as follows:

> Defendants shall, within 90 days and without limitation, pursuant to its obligation under the Colorado Medicaid State Plan, make available to Plaintiffs Mandy R., Lisa W., Stephanie F., Cathy G., and Marian L., ICF/MR level services in an appropriate public ICF/MR facility (or private setting if the Defendants and Plaintiffs so agree). Such ICF/MR placement shall be appropriate to meet the needs of each Plaintiff specified above, consistent with the findings of this Court, but need not be made available if any Plaintiff's legal guardian declines the placement.
>
> The Court declares that Jodi F.'s rights to necessary prompt services and to comparable medical services was denied because of the delay in receipt of ICF/MR services to her.
>
> At the invitation of the Defendants, and provided they give their consent thereto, the Court will require the Defendants to develop a plan within the next 180 days to remedy the waiting list problem for those persons identified as needing comprehensive services as soon as available" or prior to the end of fiscal year 2005. The Court makes this Order mindful of the fact that this case was not certified as a class action and therefore, similarly situated persons may decide to initiate litigation against the Defendants on the same basis that the Plaintiffs brought their claims here. If the Defendants choose not to develop a plan, then the Plaintiffs may file a renewed, more focused motion for

> class cedification. The Court will grant the Defendants 30 days from this Order to determine if they wish to file a plan and the Plaintiffs 30 days thereafter to file a renewed motion for class certification, if such becomes necessary. The Court will not enter final judgment in this case for 90 days pending the filing of additional motions.
>
> The Court further Orders the Defendants to promptly inform and provide factually neutral information to all persons or corporations who may inquire as to the process and procedure to become a Medicaid provider in the State of Colorado in order to operate a private ICF/MR facility. Such information shall include the rates at which such a facility would be paid were it to become a licensed Medicaid provider.

(Plaintiffs' Proposed Findings of Fact, Conclusions of Law and Order, at 27-28). The Intervenor asks for the following relief:

> An appropriate remedy for the State of Colorado's violation of § 1396(a)(30)(A) would be a 10% increase in comprehensive base rates per year for 3 years or 33% after compounding. This number directly tracks the 33% increase proposed by the State of Colorado in CACCB Ex. A-9 at 14, and the recommendation made by ECI in its 2000 report, CACCB Ex. 10 at 58, calling for a 46.4% increase, which equals 10% compounded for four years. Rice Tr. at Vol. IV, 90:2 - 91:9.

(CACCB's Proposed Findings of Fact, at ¶ 76).

What is clear from the evidence is that the defendants could not comply with such orders without obtaining substantial funding beyond what has been provided to them. In effect, this court would be saying that the Colorado General Assembly must either withdraw that much of the State Plan that provides for medical assistance to developmentally disabled adults or make changes necessary in taxation or appropriation to substantially increase funding to expand the capacity for providing care and raise the rates for payment to care providers. If the defendants were to fail to comply with these directives are they to be jailed for contempt or would CMS be considered to be in default of its statutory responsibility to prohibit further funding for a plan that fails to meet the statutory requirements?

In summary, the declaratory relief requested by the plaintiffs and Intervenor must be declined because such a judgment would intrude into the authority and responsibility of those who are accountable to the electorate. There is no more fundamental principle of democratic government than that which reserves to the people the power to tax and spend. It is therefore

ORDERED, that judgment will enter for the dismissal of the plaintiffs' and Intervenor's claims with the defendants' costs to be taxed.

DATED: February 28th, 2005

BY THE COURT:

/s/
Richard P. Matsch, Senior District Judge

APPENDIX E

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 00-M-1609 (BNB)

[Admitted June 1, 2004]

MANDY R., et al.,	)
	)
v.	)
	)
BILL OWENS, et at.,	)
	)
Defendants.	)
	)

STIPULATION OF FACTS

The parties, through counsel, hereby stipulate to the following facts in regards to Plaintiffs' First Claim (Reasonable Promptness) and Second Claim (Comparability):

I. DEFINITIONS

A. ICF/MR Facility

1. An Intermediate Care Facility for the Mentally Retarded (ICF/MR Facility) is an "active-treatment" residential facility (4 or more beds) for persons with developmental disabilities. ICF/MR services are an

optional Medicaid benefit in which Colorado currently participates. 42 U.S.C. § 1396d(d).

2. "Active treatment" means an aggressive, consistent implementation of a program specialized and generic training, treatment, health and related services. Active treatment is determined through a comprehensive functional assessment and an individual program plan. *See* 42 CFR § 483.440.

B. HOME AND COMMUNITY SERVICES FOR THE DEVELOPMENTALLY DISABLED (HCBS-DD)

3. These services are provided as an alternative to ICF/MR services. They are typically provided in private homes or apartments, group homes or host homes.

4. HCBS-DD availability is capped pursuant to an approved waiver from the Center for Medicare and Medicaid Services (CMS). This federal agency was formerly known as the Health Care Financing Administration (HCFA).

5. Home and Community Based Services for adults (over 18 years of age) with developmental disabilities are currently provided under two HCBS Waivers designated as the Home and Community Based Waiver for the Developmentally Disabled, also referred to as the Comprehensive Habilitation Services Waiver; and the Supported Living Service Waiver (SLS Waiver).

II. ICF/MR FACILITIES IN COLORADO

Colorado currently has three ICF/MR facilities. They are as follows:

6. Grand Junction Regional Center (GJRC). This Center, located on a state-owned campus in Grand Junction, Colorado, currently serves 42 individuals in the ICF portion, 28 in skilled nursing home (SNF) portion, with plans in the next few months to have 45 individuals in the ICF portion and 30 in SNF. The services are provided in ten residential sites on campus. There are four to thirteen individuals in each site. Thirteen individuals currently receiving services are offenders while the remainder have high needs for medical or behavioral services, besides their DD diagnosis.

7. Kipling Village at Wheat Ridge Regional Center (WRRC). This state-owned and operated facility currently serves 28 individuals, and the capacity is 29. The population is typically sex offenders and high risk persons. The facility provides services in campus settings in five state-owned and operated group homes on the WRRC campus. There are up to six individuals in each group home.

8. Good Shepherd. Good Shepherd is a privately-run facility which participates in the Medicaid program. It provides care for sixteen people in four separate ranch style group homes in the community. This facility is currently operated for developmentally disabled persons with high medical needs.

9. There are 21 individuals on waiting lists for ICF/MR. This list only includes persons who have been formally

referred to an ICF/MR, and does not include individuals identified by the Community Center Boards (CCB's) as needing comprehensive residential services but not referred. The 21 individuals are currently residing with their families, in nursing homes, jails or prisons, the Colorado Mental Health Institute at Pueblo or Fort Logan, or are living in the community DD system.

10. Colorado has been downsizing state-operated ICF/MR facilities since the late 1970s. Colorado has emphasized serving persons in the community. Relative to state population, fewer people were served in Colorado institutions than in a substantial number of other states.

11. The state has cut back its own role as a direct service provider, relying more in recent years on CCBs and other private providers.

III. COMMUNITY CENTERED BOARDS

12. Each CCB keeps a separate waiting list for its residential services.

13. There are 20 Community Centered Boards designated by defendants to administer services to the developmentally disabled in their geographical area and to enroll persons onto waiting lists. They are described at C.R.S. §§ 27-10.5-101-139. Each CCB covers a geographic area of 1 to 10 counties. CCBs, on behalf of defendants, perform intake, eligibility determinations, service plan development, arrangement for services, delivery of services (directly or through purchase), monitoring, and other functions. CCBs maintain waiting lists for residential services, except for ICF/MR services. Once a determination is made that an individual is eligible

for developmental disability services, the CCB must designate a case manager and develop an individual plan for him or her.

14. The Colorado Association of Community Centered Boards (CACCB) is a nonprofit association that represents the 20 CCBs in the State of Colorado.

IV. WAITING LISTS

15. Individuals are placed on a waiting list until residential services appropriate for their needs become available. The state and the CCBs differ on the size and composition of the list. The state measures the waiting list for comprehensive needs in quarterly management reports. These reports from August 2000 to current are stipulated exhibits. It is not always possible to identify why people may not want services as the desire to accept services is affected by a number of variables which are not measurable or quantifiable.

16. As of 12/31/03, the state estimated that 713 people were on waiting lists and want services as soon as they can become available. An additional 80 on waiting lists want services in the first fiscal year (2004) and another 99 people have stated they want services in the next fiscal year (2005). This totals 892 persons.

17. The length of the waiting list for residential services varies by CCB, so that one CCB may have a longer list and another may have a shorter one.

18. On February 27, 2004, the Colorado Legislative Joint Budget Committee (JBC) did not approve any additional waiting list slots for 2004-2005.

V. COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCENG (HCPF)

19. Defendant, Colorado Department of Health Care Policy and Financing is the "single state agency" for the State of Colorado that administers the Medicaid program under Title XIX of the Social Security Act.

20. Good Shepherd, Kipling Village and Grand Junction Regional Center participate in the Medicaid program.

21. Karen Reinertson is the current Executive Director of HCPF and, as such, is responsible for the administration of all Medicaid programs in the state.

22. Defendant Reinertson is aware that a waiting list exists for residential services for the developmentally disabled.

23. HCPF has entered into an interagency agreement with the Department of Human Services (DHS) for DHS to administer Medicaid services for the developmentally disabled.

VI. COLORADO DEPARTMENT OF HUMAN SERVICES (DHS)

24. DHS is the state agency responsible for the administration and operation of state programs for the developmentally disabled.

25. DHS is responsible for developing and implementing the provisions of the Medicaid Home and Community Based Services ("HCBS") for persons with developmental disabilities such as Plaintiffs.

26. Defendant Hammons is the Executive Director of Defendant DHS and has oversight responsibility for all programs administered by DHS, including those provided in conjunction with Defendant HCPF.

27. Defendant Hammons is aware that a waiting list exists for residential services for the developmentally disabled.

VII. FACTS RELEVANT TO PLAINTIFFS

A. Mandy R.

28. Plaintiff Mandy R is the daughter of Mr. & Mrs. R.

29. Mandy R.'s parents are also her guardians.

30. Mandy R. is 28 years old and is autistic.

31. Mandy R. applied to the local community centered board for residential services when she was a teenager.

32. Prior to 2001, Mandy R. continued to live at home while on the waiting list for residential services.

33. Mandy R. was enrolled in comprehensive services 5/20/2001 after being prioritized on the waiting list in response to an emergency request by her family.

34. Mandy R. attends a program at the Weiland Center 4 days a week.

35. At all relevant times Mandy R. has been categorically eligible for Medicaid and met the ICF/MR eligibility criteria.

B. Stephanie F.

36. Plaintiff Stephanie F. is the daughter of Mr. & Mrs. F.

37. Stephanie F. is 28 years old and has a pervasive developmental disorder and a seizure disorder.

38. Stephanie F. also has an anxiety disorder.

39. Stephanie F. currently lives at home with her parents while she awaits residential placement.

40. Stephanie F. has been on the waiting list for residential services since March 17, 1999.

41. At all relevant times Stephanie F. has been categorically eligible for Medicaid and met the ICF/MR eligibility criteria.

C. Lisa W.

42. Plaintiff Lisa W. is the daughter of Mr. & Mrs. W.

43. Lisa W. is 34 years old and has apparent intellectual and cognitive deficits as a result of Downs Syndrome and related developmental disabilities.

44. Lisa W. has also been diagnosed with a heart murmur and mild to moderate conductive hearing loss.

45. Lisa W. was living with her family while she awaited residential placement.

46. Lisa W. was on a waiting list for residential services since September 1997.

47. Lisa W. was placed in a host home in March of 2003.

48. At all relevant times Lisa W. has been categorically eligible for Medicaid and met the ICF/MR eligibility criteria.

D. Cathy G.

49. Cathy G. is the daughter of Russell G. who is also her guardian.

50. Cathy is now 47 years old.

51. Cathy's IQ has been evaluated at 45.

52. Her diagnoses include: moderate mental retardation, schizoaffective disorder (depressed type), grand mal seizure disorder (none for three years), history of diabetes insipidus, elevated proactin level, acute mild renal insufficiency, poor vision, post surgery for nasal polyposis, history of respiratory problems, including on one occasion being intubated, aggression.

53. Cathy lived at home, with the exception of one out-of-home placement at age 14, until she was 25.

54. Cathy has had one group home placement in excess of ten psychiatric hospital admissions, numerous host home placements, respite care placements and repeated stays back in her father's home since 1980.

55. Cathy was transferred to Ft. Logan Mental Health Institute on 1/5/00.

56. In August 2001 Cathy was evaluated and found eligible and appropriate for state regional center placement and was also referred to the regional centers. An appropriate placement in the DD system was identified by Denver Options and Cathy was discharged from Ft. Logan on 9/12/02. Cathy lived in Host Home from 9/12/03 until 1/24/03, and then moved to another Host Home. Cathy has resided in her current Host Home since 1/24/03. She receives 1:1 day program services.

57. At all relevant times, Cathy G. has been categorically eligible for Medicaid and has met the ICF/MR eligibility criteria.

E. Marian L.

58. Marian L. is the 3 l-year-old the adopted daughter of Ms. L who is her legal guardian.

59. Marian currently lives at home with her mother.

60. Marian has received HCBS-EBD through her county Department of Social Services since 8/23/96. These services do not include residential or respite services.

61. Marian was born with fetal alcohol syndrome. She has a pervasive developmental disorder, a hearing impairment requiring her to use some sign language in addition to speech, Coffin Sirus disorder, poor balance, neurogenic bladder (necessitating the need for diapers), a spinal fusion with placement of a rod in her spine, and food allergies among other related disabilities. Marian cannot

attend to her own medical needs and is completely dependent on her mother.

62. Marian was found eligible and placed on a waiting list for residential services on October 14, 1991.

63. Marian receives day program services through Centura Hospital.

64. At all relevant times, Marian L. has been categorically eligible for Medicaid and met the ICF/MR eligibility Criteria.

F. Jodi F.

65. Jodi F. is the 27-year-old daughter of Mr. and Mrs. F. who are also her guardians.

66. Jodi F. is nonverbal, with the exception of a few words and phrases. She has cerebal palsy, mental retardation, a seizure disorder and hearing loss.

67. Due to her multiple disabilities and cognitive deficits, Jody needs substantial and ongoing assistance with her personal care and other daily living skills.

68. Evaluation indicates that Jodi F.'s intellectual functioning is in the severe range and that she has significant deficits in adaptive behavior.

69. Jodi applied to the local CCB for residential services when she was a teenager. She was put on the ICF/MR waiting list on 8/13/01. She remained on the waiting list for residential services until her residential placement on 3/1/03.

70. One year ago she went into ICF/MR placement at Good Shepherd.

71. At all relevant times Jodi F. has been categorically eligible for Medicaid and met the ICF/MR eligibility criteria.

Respectfully submitted,

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APPENDIX F

Revision: HCPA-PM-86-20 (BERC)
March 1991

Attachment 3.1-A
Page 7
OMB NO: 0938-0193

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15.a. Intermediate care facility services (other than such services in an institution for mental diseased) for persons determined, in accordance with section 1902(a) (31) (A) of the Act, to be in need of such care.

[X] Provided: [X] No Limitations

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

[X] Provided: [X] No Limitations

16. Inpatient psychiatric facility services for individuals under 22 years of age.

[X] Provided: [X] No Limitations

17. Nurse-midwife services.

[X] Provided: [X] No Limitations

18. Hospice care (in accordance with section 1905(o) of the Act).

[X] Provided: [X] No Limitations

TN No. 91-07
Supersedes
TN No. 87-5

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APPENDIX G

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

LONG TERM CARE – GENERAL 8.403. - 8.403.11

8.403 LONG TERM CARE - SERVICES TO THE DEVELOPMENTALLY DISABLED

Long term care services for the developmentally disabled include institutional services available through Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Home and Community Based Services for the Developmentally Disabled (HCB-DD). These specialized services are available to Medicaid eligible clients who meet the target group designation for the developmentally disabled, and meet the level of care guidelines described below.

8.403.1 LEVEL OF CARE GUIDELINES FOR LONG TERM CARE SERVICES FOR THE DEVELOPMENTALLY DISABLED

Level of care guidelines for programs for the developmentally disabled are used to determine if the profile of a client's programmatic and/or medical needs are appropriate to a specific ICF/MR nursing home class or equivalent set of HCB-DD services.

.11 Clients shall be certified for admission to a specific class of ICF/MR or equivalent set of HCB-DD services based on the following criteria:

A. Minimum/Moderate - developmentally disabled clients who exhibit thefollowing characteristics:

1. Have deficiencies in adaptive behavior that preclude independent living and require a supervised sheltered living environment;
2. Need supervision and training in self help skills and activities of daily living, but do not display excessive behavior problems which are disruptive to other residents or which prevent participation in group or community activities;
3. Are capable of attending appropriate day services or engaging in sheltered or competitive employment; and,
4. Are capable of being maintained in a community-based setting.

Clients certified at this level of care may be provided Class II ICF/MR services or those HCB-DD services as set forth in the sections on HOME AND COMMUNITY BASED SERVICES FOR THE DEVELOPMENTALLY DISABLED in this manual.

8.403.1 LEVEL OF CARE GUIDELINES FOR LONG TERM CARE SERVICES FOR THE DEVELOPMENTALLY DISABLED

B. Specialized Intensive - developmentally disabled individuals whose psychological, behavioral, and/or developmental needs require 24-hour supervision, and who have potential for movement to a less restrictive living arrangement within 24 months (on the

average). These individuals must conform to one of the profiles described below:

1. Behavior development profile:

   - Function at a severe to moderate overall level of retardation;
   - May present a danger to self or others in the absence of supervision and habilitative services;
   - Display severe maladaptive and/or anti-social behaviors, and may have exhibited delinquent behaviors;
   - May display destructive or physically aggressive behaviors;
   - Need specialized behavior management, counseling, and supervision;

2. Social emotional development profile:

   - Function at a moderate to mild overall level of retardation.
   - Exhibit severe social and emotional problems attributable to a mental disorder.
   - May be verbally abusive and/or physically aggressive toward self, others, or property.
   - May display run-away, withdrawal, and/or bizarre behavior attributable to a mental disorder;
   - Need social, adaptive, and intensive mental health services.

3. Intensive developmental profile:

   - Function at a profound to severe level of mental retardation;
   - Exhibit severe deficiencies in behaviors such as eating, dressing, hygiene, toileting, and communication;
   - May display inappropriate social and/or interpersonal behaviors;
   - Need intensive self-management and adaptive behavior training.

Additionally, these individuals are capable of functioning in a community based setting.

Clients certified at this level of care may be provided Class II or Class IV ICF/MR services or those HCB-DD services as provided in the sections on HOME AND COMMUNITY BASED SERVICES FOR THE DEVELOPMENTALLY DISABLED in this manual.

C. Intensive Medical/Psychosocial - developmentally disabled individuals who have intensive medical and psychosocial needs that require highly structured, in house, comprehensive, medical, nursing and psychological treatment. These individuals must meet at least one of the following requirements:

1. Exhibits extreme deficiencies in adaptive behaviors in association with profound or severe retardation or in association with medical problems requiring availability of

medical life support services on a continuous basis; and/or

Exhibits maladaptive behavior(s) potentially injurious to self or others to the degree that intensive programming in an institutional or closed setting is required; and

Inappropriate for placement in less restrictive settings, such as minimum/moderate or specialized intensive community-based services, due to the nature and/or severity of their handicaps.

2. Appropriate for service in less restrictive community residential programs, but all local and statewide avenues for alternative placement have been investigated and exhausted prior to referral to a Class IV facility. Plans for eventual community placement have been established;

3. Committed by court action to a Regional Center under the Division for Developmental Disabilities, Department of Institutions.

Clients certified at this level of care may be provided Class IV ICF-MR services or HCB-DD services as provided in the sections on HOME AND COMMUNITY BASED SERVICES FOR THE DEVELOPMENTALLY DISABLED in this manual.

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
STAFF MANUAL VOLUME 8
MEDICAL ASSISTANCE

8.441.3 DETERMINATION OF MAXIMUM REIMBURSEMENT RATE

3. The data utilized by the Department in its determination of the reasonably practicable after the actual determination is made by the Department. The Department's establishment of the maximum reasonable rate and the data used in that computation shall be subject to administrative appeal on or before the expiration of the thirty (30) day period following the date the information is made available. If no such appeal has been filed within the time period specified above and in accordance with any other applicable rules described in this manual under provider appeals and hearings, the maximum reasonable rate established by the Department shall become final.

E. The maximum rate for reimbursement (for all nursing facilities except the State-administered Class IV facilities) shall be changed effective July 1 of each year in accordance with the findings made based on this section, and individual facility rates adjusted accordingly.

F. Class II and Class IV facility beds shall be limited by the Department on the basis of the number of beds necessary to meet the needs of

the mentally retarded patients through the use of such devices as the Department of Human Services annual certification of the number of beds necessary to meet the needs of mentally retarded patients.

THIS REVISION: VIII-96-7
Adopted: 9/13/96
Effective Date: 11/01/96

LAST REVISION: VII-88-75
Adopted: 7/08/88
Effective Date: 7/01/88
REVISION NUMBER 10

DETERMINATION OF MEDICAID ELIGIBILITY

[p. 154]

§435.911 Timely determination of eligibility.

(a) The agency must establish time standards for determining eligibility and inform the applicant of what they are. These standards may not exceed-

(l) Ninety days for applicants who apply for Medicaid on the basis of disability; and

(2) Forty-five days for all other applicants.

(b) The time standards must cover the period from the date of application to the date the agency mails notice of its decision to the applicant.

(c) The agency must determine eligibility within the standards except in unusual circumstances, for example-

(l) When the agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action, or

(2) When there is an administrative or other emergency beyond the agency's control.

(d) The agency must document the reasons for delay in the applicant's case record.

(e) The agency must not use the time standards-

(l) As a waiting period before determining eligibility; or

(2) As a reason for denying eligibility (because it has not determined eligibility within the time standards).

[44 FR 17937. Mar. 23, 1979, as amended, at 45 FR 24887, Apr. 11, 1980; 54 FR 50762, Dec. 11, 1989]

§435.912 Notice of agency's decision concerning eligibility.

The agency must send each applicant a written notice of the agency's decision on his application, and, if eligibility is denied, the reasons for the action, the specific regulation supporting the action, and an explanation of his right to request a hearing. (See subpart E of part 431 of this subchapter for rules on hearings.)

[44 FR 17937, Mar. 23, 1979, as amended at 51 FR 7211, Feb. 28, 1986]

§ 435.913 Case documentation.

(a) The agency must include in each applicant's case record facts to support the agency's decision on his application.

(b) The agency must dispose of each application by a finding of eligibility or ineligibility, unless-

(l) There is an entry in the case record that the applicant voluntarily withdrew the application, and that the agency sent a notice confirming his decision;

(2) There is a supporting entry in the case record that the applicant has died; or

(3) There is a supporting entry in the case record that the applicant cannot be located.

§ 435.914 Effective date.

~~(a)~~ The agency must make eligibility for Medicaid effective no later than the third month before the month of application if the individual-

(l) Received Medicaid services, at any time during that period, of a type covered under the plan; and

(2) Would have been eligible for Medicaid at the time he received the services if he had applied (or someone had applied for him), regardless of whether the individual is alive when application for Medicaid is made.

(b) The agency may make eligiblity for Medicaid effective on the first day of a month if an individual was eligible at any time during that month.

(c) The State plan must specify the date on which eligibility will be made effective.

REDETERMINATIONS OF MEDICAID ELIGIBILITY

§435.916 Periodic redeterminations of Medicaid eligibility.

(a) The agency must redetermine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months, however-

(l) The agency may consider blindness as continuing until the review physician under §435.531 determines that a recipient's vision has improved beyond the definition of blindness contained in the plan; and

(2) The agency may consider disability as continuing until the review team under §435.541 determines that a recipient's disability no longer meets

[p. 155]

the definition of disability contained in the plan.

(b) *Procedures for reporting changes.* The agency must have procedures designed to ensure that recipients make timely

and accurate reports of any change in circumstances that may affect their eligibility.

(c) *Agency action on information about changes.*

(1) The agency must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his eligibility.

(2) If the agency has information about anticipated changes in a recipient's circumstances, it must redetermine eligibility at the appropriate time based on those changes.

§435.919 Timely and adequate notice concerning adverse actions.

(a) The agency must give recipients timely and adequate notice of proposed action to terminate, discontinue, or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid.

(b) The notice must meet the requirements of subpart E of part 431 of this subchapter.

[44 FR 17937, Mar. 23, 1979, as amended at 45 FR 24887, Apr. 11, 1980; 51 FR 7211, Feb. 28, 1986]

§ 435.920 Verification of SSNs.

(a) In redetermining eligibility, the agency must review case records to determine whether they contain the recipient's SSN or, in the case of families, each family member's SSN.

(b) If the case record does not contain the required SSNs, the agency must require the recipient to furnish them and meet other requirements of § 435.910.

(c) For any recipient whose SSN was established as part of the *case* record without evidence required under the SSA regulations as to age, citizenship, alien status, or true identity, the agency must obtain verification of these factors in accordance with § 435.910.

[44 FR 17937, Mar. 23, 1979, as amended at 51 FR 7211, Feb. 28, 1986]

FURNISHING MEDICAID

§435.930 Furnishing Medicaid.

The agency must--

(a) Furnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures;

(b) Continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible; and

(c) Make arrangements to assist applicants and recipients to get emergency medical care whenever needed, 24 hours a day and 7 days a week.

INCOME AND ELIGIBILITY VERIFICATION REQUIREMENTS

SOURCE: Sections 435.940 through 935.965 appear at 51 FR 7211, Feb. 28, 1986, unless otherwise noted.

§ 435.940 Basis and scope.

(a) Section 1137 of the Act requires certain Federally-funded, State-administered public assistance programs to establish procedures for obtaining, using and verifying information relevant to determinations as to eligibility and the

amount of assistance. Section 1902(a)(4) of the Act allows the Secretary to prescribe methods of administration found necessary for the proper and efficient operation of a State's Medicaid plan.

(b) The agency must maintain information, as enumerated in §435.960, to exchange for the purpose of enabling any agency or program referenced in §435.945(b) to verify income, eligibility of, and the amount of assistance for its applicants and recipients.

§435.945 General requirements.

(a) The agency must request and use information timely in accordance with §§435.948, 435.952, and 435.953 of this subpart for verifying Medicaid eligibility and the amount of medical assistance payments.

(b) The agency must furnish timely to other agencies in the State and in other States and to Federal programs income, eligibility and medical assistance payment information for verifying eligibility or benefit amounts for the programs listed in §435.948(a)(6) of this subpart. In addition, the agency must furnish income and eligibility information to–

[p. 249]

436.406(b) and 436.406(c) of this sub-chapter will only be provided the limited services specified in § 440.255.

[56 FR 24011. May 28, 1991, as amended at 58 FR 4938, Jan. 19, 1993]

§440.225 Optional services.

Any of the services defined in subpart A of this part that are not required under §§440.210 and 440.220 may be furnished under the State plan at the State's option.

[60 FR 19862, Apr. 21, 1995]

§440.230 Sufficiency of amount, duration, and scope.

(a) The plan must specify the amount, duration, and scope of each service that it provides for--

(1) The categorically needy; and

(2) Each covered group of medically needy.

(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

(c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

[46 FR 47993, Sept. 30, 1981]

§ 440.240 Comparability of services for groups.

Except as limited in §440.250--

(a) The plan must provide that the services available to any categorically needy recipient under the plan are not less in amount, duration, and scope than those services available to a medically needy recipient; and

(b) The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group:

(1) The categorically needy.

(2) A covered medically needy group.

[46 FR 47993, Sept. 30, 1981]

§440.250 Limits on comparability of services.

(a) Skilled nursing facility services (§440.40(a)) may be limited to recipients age 21 or older.

(b) Early and periodic screening, diagnosis, and treatment (§ 440.40(b)) must be limited to recipients under age 21.

(c) Family planning services and supplies must be limited to recipients of childbearing age, including minors who can be considered sexually active and who desire the services and supplies.

(d) If covered under the plan. services to recipients in institutions for mental diseases (§ 440.140) must be limited to those age 65 or older.

(e) If covered under the plan, inpatient psychiatric services (§440.160) must be limited to recipients under age 22 as specified in §441.151(c) of this sub-chapter.

(f) If Medicare benefits under Part B of title XVIII are made available to recipients through a buy-in agreement or payment of premiums, or part or all of the deductibles, cost sharing or similar charges, they may be limited to recipients who are covered by the agreement or payment.

(g) If services in addition to those offered under the plan are made available under a contract between the agency or political subdivision and an organization providing comprehensive health services, those additional services may be limited to recipients who reside in the geographic area served by the

contracting organization and who elect to receive services from it.

(h) Ambulatory services for the medically needy (§440.220(a)(2)) may be limited to:

(1) Individuals under age 18; and

(2) Groups of individuals entitled to institutional services.

(i) Services provided under an exception to requirements allowed under §431.54 may be limited as provided under that exception.

(j) If CMS has approved a waiver of Medicaid requirements under §431.55, services may be limited as provided by the waiver.

(k) If the agency has been granted a waiver of the requirements of §440.240 (Comparability of services) in order to provide for home or community-based

[p. 564]

developmental, behavioral, and health needs.

(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

(4) Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.

§483.440 Condition of participation: Active treatment services.

(a) *Standard: Active treatment.*

(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic

training, treatment, health services and related services described in this subpart, that is directed toward--

(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and

(ii) The prevention or deceleration of regression or loss of current optimal functional status.

(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

(b) *Standard: Admissions, transfers, and discharge.*

(1) Clients who are admitted by the facility must be in need of and receiving active treatment services.

(2) Admission decisions must be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.

(3) A preliminary evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

(4) If a client is to be either transferred or discharged, the facility must--

(i) Have documentation in the client's record that the client was transferred or discharged for good cause; and

(ii) Provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies).

(5) At the time of the discharge, the facility must-

(i) Develop a final summary of the client's developmental, behavioral, social, health and nutritional status and, with the consent of the client, parents (if the client is a

minor) or legal guardian, provide a copy to authorized persons and agencies; and

(ii) Provide a post-discharge plan of care that will assist the client to adjust to the new living environment.

(c) *Standard: Individual program plan.*

(1) Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to-

(i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and

(ii) Designing programs that meet the client's needs.

(2) Appropriate facility staff must participate in interdisciplinary team meetings. Participation by other agencies serving the client is encouraged. Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless that participation is unobtainable or inappropriate.

(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassess-ments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment must take into consideration the client's age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and must--

(i) Identify the presenting problems and disabilities and where possible, their causes;

(ii) Identify the client's specific developmental strengths;

[p. 576]

(i) Assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients; and

(ii) Precludes any commingling of client funds with facility funds or with the funds of any person other than another client.

(2) The client's financial record must be available on request to the client, parents (if the client is a minor) or legal guardian.

(c) *Standard: Communication with clients, parents, and guardians.* The facility must--

(1) Promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate;

(2) Answer communications from clients' families and friends promptly and appropriately;

(3) Promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate;

(4) Promote visits by parents or guardians to any area of the facility that provides direct client care services to the client, consistent with the right of that client's and other clients' privacy;

(5) Promote frequent and informal leaves from the facility for visits, trips, or vacations; and

(6) Notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

(d) *Standard: Staff treatment of clients.* (1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

(i) Staff of the facility must not use physical, verbal, sexual or psychological abuse or punishment.

(ii) Staff must not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.

(iii) The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

(3) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident and, if the alleged violation is verified, appropriate corrective action must be taken.

§483.430 Condition of participation: Facility staffing.

(a) *Standard: Qualified mental retardation professional.* Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional who--

(1) Has at least one year of experience working directly with persons with mental retardation or other developmental disabilities; and

(2) Is one of the following:

(i) A doctor of medicine or osteopathy.

(ii) A registered nurse.

(iii) An individual who holds at least a bachelor's degree in a professional category specified in paragraph (b)(5) of this section.

(b) *Standard: Professional program services.*

(1) Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. Professional program staff must work directly with clients and with paraprofessional, nonprofessional and other professional program staff who work with clients.

42. THE PUBLIC HEALTH AND WELFARE
CHAPTER 7. SOCIAL SECURITY ACT
TITLE XIX. GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

§ 1396a. State plans for medical assistance

(a) Contents.

A State plan for medical assistance must--

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchapter; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds

from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, (C) that each State or local officer, employee, or independent contractor who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer, employee, or contractor, and each partner of such an officer, employee, or contractor shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or

employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of title 18, and (D) that each State or local officer, employee, or independent contractor who is responsible for selecting, awarding, or otherwise obtaining items and services under the State plan shall be subject to safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) to persons described in subsection (a)(2) of such section of that Act;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State Plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with–

(A) the administration of the plan; and

(B) at State option, the exchange of information necessary to verify the certification of eligibility of children for free or reduced price breakfasts under the Child Nutrition Act of 1966 and free or reduced price lunches under the Richard B. Russell National School Lunch Act, in accordance with section 9(b) of that Act, using data standards and formats established by the State agency;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide–

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1395x(e)(9) of this title or paragraphs (16) and (17) [FN1] of section 1395x(s) of this title, or, in the case of a laboratory which is in a rural health clinic, of section 1395x(aa)(2)(G) of this title;

(10) provide–

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1396d(a) of this title, to–

(i) all individuals--

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of section 602(a)(37) [FN2], 606(h) [FN2], or 673(b) of this title, or considered by the State to be receiving such aid as authorized under section 682(e)(6) [FN2] of this title),

(II) (aa) with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) and would continue to be paid but for the enactment of that section), (bb) who are qualified severely impaired individuals (as defined in section 1396d(q) of this title, or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under subchapter XVI of this chapter if subparagraphs (A) and (B) of section 1382(c)(7) were applied without regard to the phrase "the first day of the month following",

(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients); or

(XIX) who are disabled children described in subsection (cc)(1) of this section;

(B) that the medical assistance made available to any individual described in subparagraph (A)--

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1396d(a) of this title who are not described in subparagraph (A) or (E), then--

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii) the plan must make available medical assistance--

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care facility for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title or the care and services listed in any 7 of the paragraphs numbered (1) through (24) of such section;

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services; and

(E)(i) but, for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title;

(ii) for making medical assistance available for payment of medicare cost-sharing described in section 1396d(p)(3)(A)(i) of this title for qualified disabled and working individuals described in section 1396d(s) of this title;

(iii) for making medical assistance available for medicare cost sharing described in section 1396d(p)(3)(A)(ii) of this title subject to section 1396d(p)(4) of this title, for individuals who would be qualified medicare beneficiaries

described in section 1396d(p)(1) of this title but for the fact that their income exceeds the income level established by the State under section 1396d(p)(2) of this title but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved; and

42 USCS § 1396d. Definitions
For purposes of this subchapter--

(a) Medical assistance. The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1) of this section, if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are--

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,

(ii) relatives specified in section 606(b)(1) of this title with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of subchapter IV of this chapter,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under subchapter I, X, XIV, or XVI of this chapter,

(vii) blind or disabled as defined in section 1382c of this title, with respect to States not eligible to participate in the State plan program established under subchapter XVI of this chapter,

(viii) pregnant women,

(ix) individuals provided extended benefits under section 1396r-6 of this title,

(x) individuals described in section 1396a(u)(1) of this title,

(xi) individuals described in section 1396a(z)(1) of this title,

(xii) employed individuals with a medically improved disability (as defined in subsection (v) of this section), or

(xiii) individuals described in section 1396a(aa) of this title, Probably means the subsec. (aa) of this section 1396a relating to certain breast or cervical cancer patients.

but whose income and resources are insufficient to meet all of such cost--

(1) inpatient hospital services (other than services in an institution for mental diseases);

(2) (A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (1)(1) of this section) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (1)(1) of this section) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (1)(2) of this section) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4) (A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) for individuals who are eligible under the plan and are under the age of 21; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

(5) (A) physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist (described in section 1395x(r)(2) of this title) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause

(A) if furnished by a physician (as defined in section 1395x(r)(1) of this title);

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

(14) inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases;

(15) services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with section 1396a(a)(31) of this title, to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h) of this section;

(17) services furnished by a nurse-midwife (as defined in section 1395x(gg) of this title) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider, and without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle;

(18) hospice care (as defined in subsection (o) of this section);

(19) case management services (as defined in section 1396n(g)(2) of this title) and TB-related services described in section 1396a(z)(2)(F) of this title;

(20) respiratory care services (as defined in section 1396a(e)(9)(C) of this title);

(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider;

(22) home and community care (to the extent allowed and as defined in section 1396t of this title) for functionally disabled elderly individuals;

(23) community supported living arrangements services (to the extent allowed and as defined in section 1396u of this title);

(24) personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location;

(25) primary care case management services (as defined in subsection (t) of this section);

42 USCS § 1396n. Compliance with State plan and payment provisions

(c) Waiver respecting medical assistance requirement in State plan; scope, etc.; "habilitation services" defined; imposition of certain regulatory limits prohibited; computation of expenditures for certain disabled patients; coordinated services; substitution of participants.

(1) The Secretary may by waiver provide that a State plan approved under this subchapter may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term "room and board" shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that–

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver

and to assure financial accountability for funds expended with respect to such services;

(B) the State will provide, with respect to individuals who–

(i) are entitled to medical assistance for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based care under such waiver, for an evaluation of the need for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;

(C) such individuals who are determined to be likely to require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;

(D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

(E) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this

subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability), and section 1396a(a)(10)(C)(i)(III) of this title (relating to income and resource rules applicable in the community). A waiver under this subsection shall be for an initial term of three years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under the regulations in effect on July 1, 1985.

(4) A waiver granted under this subsection may, consistent with paragraph (2)--

(A) limit the individuals provided benefits under such waiver to individuals with respect to whom the State has determined that there is a reasonable expectation that the amount of medical assistance provided with respect to the individual under such waiver will not exceed the amount of such medical assistance provided for such individual if the waiver did not apply, and

(B) provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject

to the approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.

Except as provided under paragraph (2)(D), the Secretary may not restrict the number of hours or days of respite care in any period which a State may provide under a waiver under this subsection.

(5) For purposes of paragraph (4)(B), the term "habilitation services"--

(A) means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings; and

(B) includes (except as provided in subparagraph (C)) prevocational, educational, and supported employment services; but

(C) does not include--

(i) special education and related services (as such terms are defined in section 1401 of Title 20), which otherwise are available to the individual through a local educational agency; and

(ii) vocational rehabilitation services which otherwise are available to the individual through a program funded under section 730 of Title 29).

(6) The Secretary may not require, as a condition of approval of a waiver under this section under paragraph (2)(D), that the actual total expenditures for home and community-based services under the waiver (and a claim for Federal financial participation in expenditures for the services) cannot exceed the approved estimates for these services. The Secretary may not deny Federal financial payment with respect to services under such a waiver on the ground that, in order to comply with paragraph (2)(D), a State has failed to comply with such a requirement.

(7) (A) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with a particular illness or condition who are inpatients in, or who would require the level of care provided in, hospitals, nursing facilities, or intermediate care facilities for the mentally retarded, the State may determine the average per capita expenditure that would have been made in a fiscal year for those individuals under the State plan separately from the expenditures for other individuals who are inpatients in, or who would require the level of care provided in, those respective facilities.

(B) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with developmental disabilities who are inpatients in a nursing facility and whom the State has determined, on the basis of an evaluation under paragraph (2)(B), to need the level of services provided by an intermediate care facility for the mentally retarded, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals under the State plan on the basis of the average per capita expenditures under the State plan for services to individuals who are inpatients in an intermediate

care facility for the mentally retarded, without regard to the availability of beds for such inpatients.

(C) In making estimates under paragraph (2)(D) in the case of a waiver to the extent that it applies to individuals with mental retardation or a related condition who are resident in an intermediate care facility for the mentally retarded the participation of which under the State plan is terminated, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals without regard to any such termination.

(8) The State agency administering the plan under this subchapter may, whenever appropriate, enter into cooperative arrangements with the State agency responsible for administering the program for children with special health care needs under title V of this chapter in order to assure improved access to coordinated services to meet the needs of such children.

(9) In the case of any waiver under this subsection which contains a limit on the number of individuals who shall receive home or community-based services, the State may substitute additional individuals to receive such services to replace any individuals who die or become ineligible for services under the State plan.

(10) The Secretary shall not limit to fewer than 200 the number of individuals in the State who may receive home and community-based services under a waiver under this subsection.